

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09047

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) CHARLES K ABBOTT			2a. DATE OF DEATH MONTH DAY YEAR 4-2-84		2b. HOUR 7:45 PM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH 9-19-38 YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 50 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION GAF CORPORATION		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MARYLAND 13b COUNTY ANNE ARUNDEL 13c CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 132 RUETHE DRIVE 21403		
14. FATHER'S NAME FIRST MIDDLE LAST EDWARD ABBOTT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HILDA GARNER XXXXXX			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-28-3001		17. INFORMANT ADDRESS SHIRLEY A. ABBOTT SAME AS 13E	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO, OR AS A CONSEQUENCE OF (b) Septic shock DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Urinary tract Infection Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Adenocarcinoma of prostate, Diabetes, neurogenic bladder					
19a. DATE OF OPERATION 5990		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 3600		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 3600 , 19 84 , to 4 2 , 19 84 , that (1) (we) lost saw the deceased alive on 4 2 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated (above) (below) (did) (did not) view the body after death.					
22b. SIGNATURE George C. Samaras		DEGREE		22c. DATE SIGNED 4/3/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George C. Samaras		22e. ADDRESS 205 Ridgely Ave Annapolis, MD 21401		22f. DATE REC'D. BY REGISTRAR	
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 4-5-84		23c. NAME OF CEMETERY OR CREMATORY CEDAR BLUFF CEMETERY	
23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS ANNE ARUNDEL CO.		24. FUNERAL DIRECTOR NAME ADDRESS ROBERT E. EVANS ANNAPOLIS, MARYLAND			

BP

APR 11 1984

11

[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]

11/11/11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09048

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FREDERICK Thomas ARDIS			2a. DATE OF DEATH MONTH DAY YEAR April 18, 1984		2b. HOUR 9:50 PM
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 11, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Severn	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7828 Locust Wood Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mach. Operator		12b. KIND OF BUSINESS OR INDUSTRY Roper-Easter
13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Severn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Robert Ardis			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy E. Weeks		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 127/07/5134		17. INFORMANT (Wife) ADDRESS Mrs. Florence Ardis	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (c) (terminal) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION 8/25/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Upper lobectomy		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from Aug. 9, 1983 , to April 18, 1984 , that (I) (we) lost saw the deceased alive on April 18, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE B. A. deGuzman, M.D.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/19/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Benjamin A. deGuzman		22e. ADDRESS 325 Hospital Drive Glen Burnie, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 21, 1984		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Prk. Glen Burnie A.A. Md.	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home		ADDRESS Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR APR 24 1984	
25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians are retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

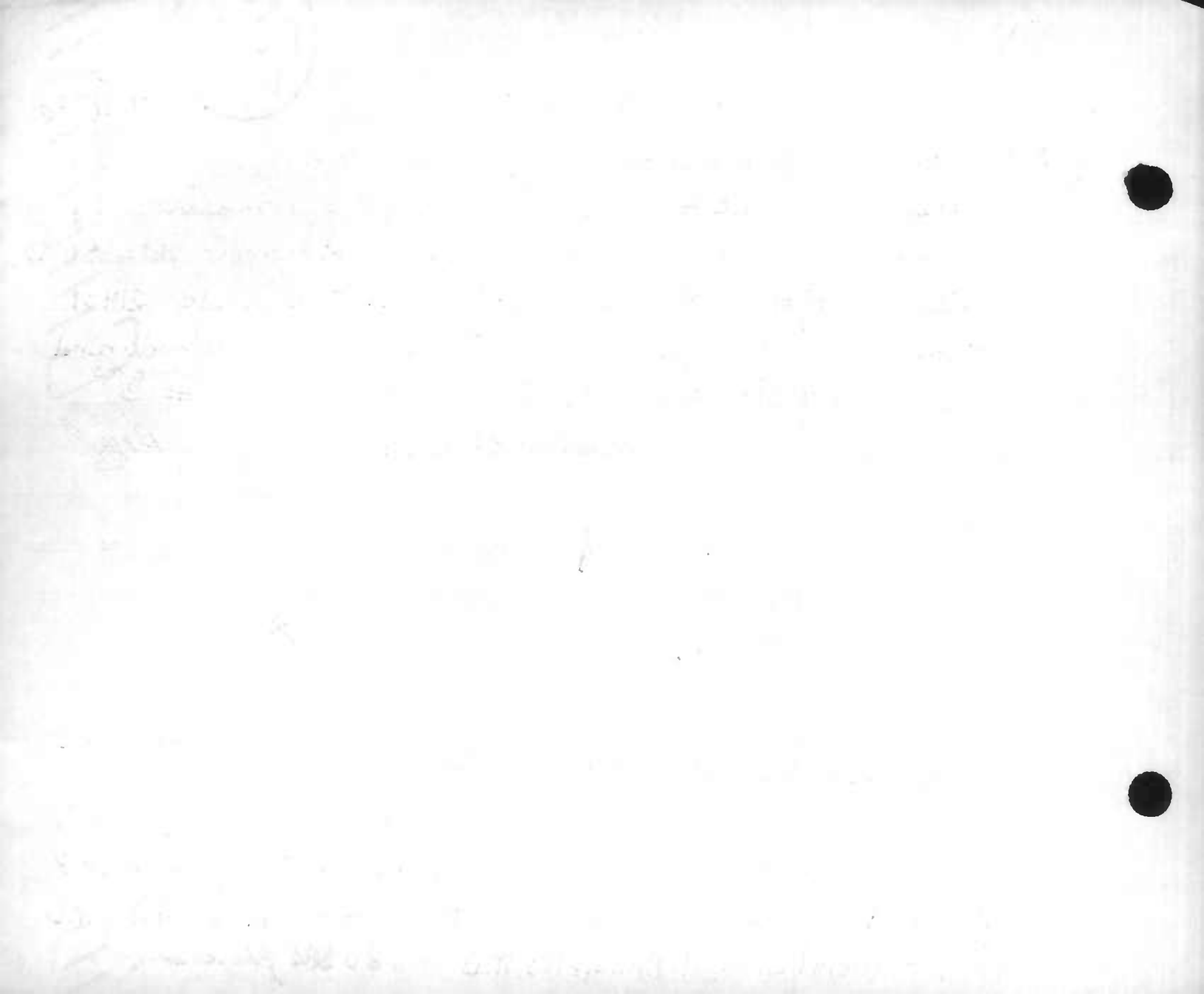
09049

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HOWARD E ARMIGER, JR.			2a. DATE OF DEATH MONTH DAY YEAR 4 21 84		2b. HOUR 11:12 AM
3. SEX male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Dec. 24, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	7. UNDER 1 YEAR MONTHS DAYS 11 12
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Court Recorder		12b. KIND OF BUSINESS OR INDUSTRY State of MD
13a. STATE MD		13b. COUNTY A.A.	13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Howard E. Armiger, Sr.		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jane Woodward		16. STREET ADDRESS / ZIP CODE 2 Ford Circle 21401	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 213-122888		17. INFORMANT Dolores A. Armiger	
17. ADDRESS Same as #13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 10/29 , 19 81 , to 4/21 , 19 84 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 4/16 , 19 84 , and that in my <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input type="checkbox"/> did not view the body after death.					
22b. SIGNATURE R.I. Hochman, MD		DEGREE MD		22c. DATE SIGNED 4/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R.I. Hochman, MD		22e. ADDRESS 16 Murray Ave Annapolis, MD 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE April 24, 1984	23c. NAME OF CEMETERY OR CREMATORY Hillcrest		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD		25a. DATE REC'D. BY REGISTRAR APR 26 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

BP _____



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09050

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CAROLINA CHRISTIN ARMSTRONG			2a. DATE OF DEATH MONTH DAY YEAR APRIL 30, 1984		2b. HOUR 7:30 A.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 3 25 1892		6. AGE (IN YEARS LAST BIRTHDAY) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY A.A.	13c. CITY OR TOWN Brooklyn	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 300 Haile Avenue 21225	
14. FATHER'S NAME FIRST MIDDLE LAST George W. Clatterbuck		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Jane Whitlock			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 216-28-7807		17. INFORMANT ADDRESS Rosalie Shifflett 606 Alden Street 21225	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST. 4860 DUE TO, OR AS A CONSEQUENCE OF (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) ---		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Fred T. Kahn</i> DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FRED T. KAHN, M.D.		22e. ADDRESS 7575 RITCHIE HIGHWAY, S.E. GLEN BURNIE, MARYLAND 21061	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/4/84	23c. NAME OF CEMETERY OR CREMATORY Woodbine Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Rockingham Co. Virginia
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24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229	25a. DATE REC'D. BY REGISTRAR MAY 2 1984	25b. REGISTRAR'S SIGNATURE <i>Fred T. Kahn</i>
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 09051			
1. DECEASED NAME (TYPE OR PRINT) Thelma Alice Arthur THELMA ALICE ARTHUR				2a. DATE OF DEATH MONTH DAY YEAR April 10, 1984			
3. SEX Female		4. RACE White CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR Nov. 14, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH CROWNSVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRFIELD ARUNDEL N.C.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Operator		12b. KIND OF BUSINESS OR INDUSTRY C&P Telephone	
13a. STATE Maryland				13b. COUNTY A.A.		13c. CITY OR TOWN Crowsville	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Reuschling				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 216/22/2563		17. INFORMANT (Husband) ADDRESS 2338 Jim Kohler Rd. Mr. Henry T. Arthur-Sykesville, Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema 4140 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular dysfunction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Atherosclerotic Heart Disease PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetes Mellitus							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (STREET CITY OR TOWN COUNTY STATE)			
22a. I certify that (I) (this hospital) attended the deceased from 1978 to 1984, that (I) (we) lost saw the deceased alive on 4/11/84 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Key Samaras				DEGREE		22c. DATE SIGNED 4/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene P. Samaras				22e. ADDRESS 205 Ridgely Ave Ann. Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 13, 1984		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Prk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.	
24. FUNERAL DIRECTOR NAME Deann P. Crutcher				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 12 1984			
Singleton Funeral Home Glen Burnie, Md							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/B2
(VRA 15, 4)TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 09052		EST	
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST NELLIE E AUSTIN					2a. DATE OF DEATH MONTH DAY YEAR APRIL 25, 1984			2b. HOUR 940 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 11, 1904		6. AGE (IN YEARS (LAST BIRTHDAY)) 80 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY AA		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1418 Washington Ave. 21144	
14. FATHER'S NAME FIRST MIDDLE LAST John Ecker					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth NA				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-74-2865		17. INFORMANT ADDRESS Mitchellville, Md 20715 Eleanor Entzian, 3009 Mill Branch Pl.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced liver carcinoma 5715 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 4-11 , 19 84 , to 4-25 , 19 84 , that (I) (we) lost saw the deceased alive on 4-25 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Sang C. Doi DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 4-28-84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SANG C. DOI, M. D.					22e. ADDRESS 95 AQUAHART ROAD GLEN BURNIE, MARYLAND 21061				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 30 April 84		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD			
24. FUNERAL DIRECTOR NAME ADDRESS James S. Kirkley, Glen Burnie, MD					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 27 1984 John Davidson				

1981

22, 1980 10:00 PM

ALICE

WILLIAM

WILLIAM



ANNE ARBUTHNOT COUNTY

NORTH ARBUTHNOT HOSPITAL

CLIN BURNING

32 ADAMANT ROAD
CLIN BURNING, WYAND 21081

DAVE C. DOW, M.D.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09053

FOR
1 - STATE
REGISTRAR

REG. NO.

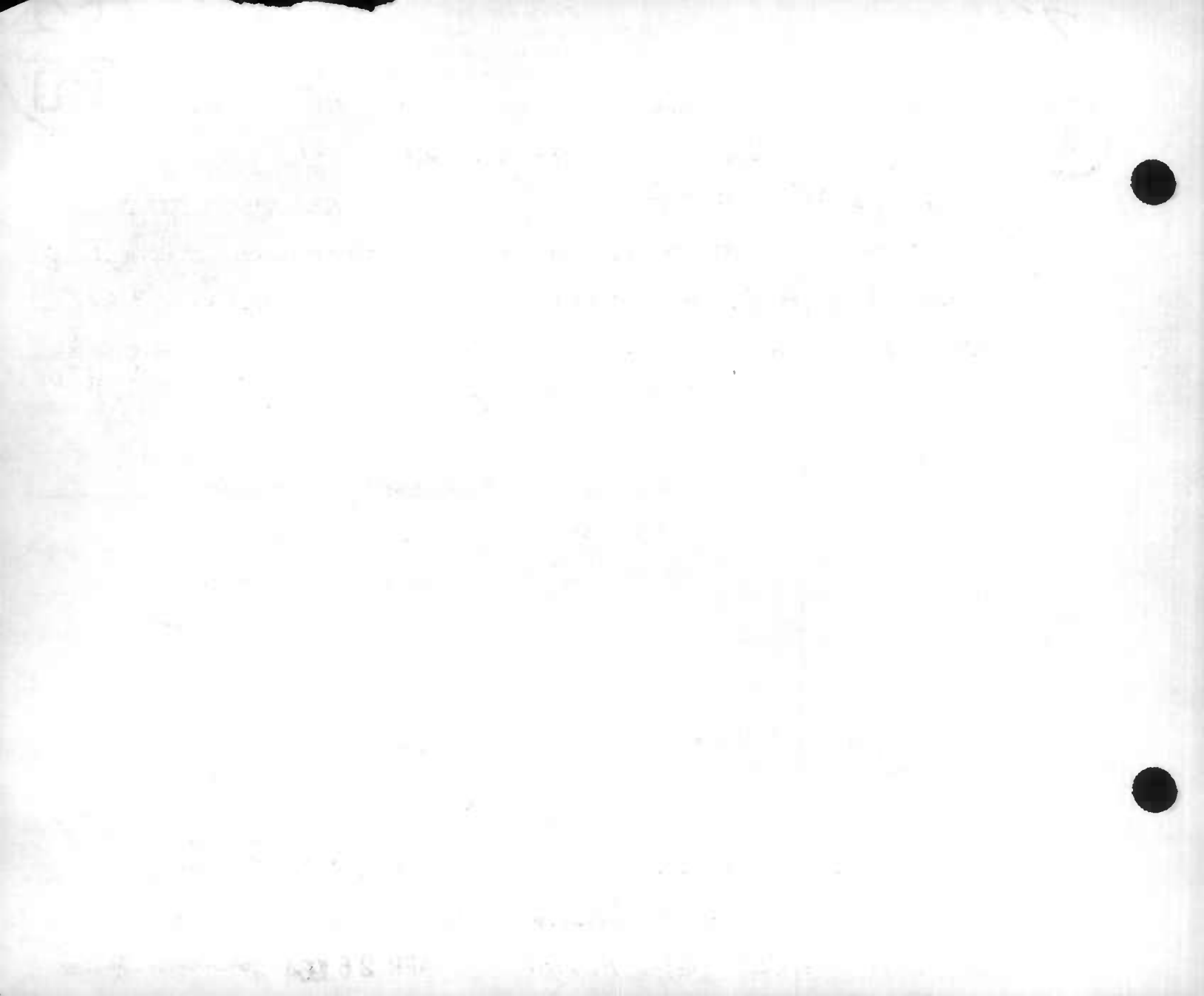
EST

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GEORGE Burton BACHMANN			2a. DATE OF DEATH MONTH DAY YEAR APRIL 24, 1984		2b. HOUR 853 PM
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 11 - 25 - 22		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Aluminum		12b. KIND OF BUSINESS OR INDUSTRY Home Imp.
13a. STATE Maryland	13b. COUNTY A.A. Co.	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 100 Terry Dr. 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick George Bachman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Hippler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. W. W. II 216-12-5958A		17. INFORMANT ADDRESS George Bachman Jr. 543 Nolfield Dr. 21061	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) ASCD APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) advanced pulmonary emphysema					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 82 to 4/24 19 84 , that (I) (we) lost saw the deceased alive on 4/24 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE James J. Benjamin, M.D.		DEGREE M.D.		22c. DATE SIGNED 4/26/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES J. BENJAMIN, M.D.		22e. ADDRESS 7300 RITCHIE HIGHWAY GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-28-84	23c. NAME OF CEMETERY OR CREMATORY Loudon Park		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. City Md.	
24. FUNERAL DIRECTOR NAME Raymond C. Fink		ADDRESS Glen Burnie		25a. DATE REC'D. BY REGISTRAR APR 26 1984	25b. REGISTRAR'S SIGNATURE Gelia Davidson-Randee

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09054

1- FOR
STATE
REGISTRAR

REG. NO.

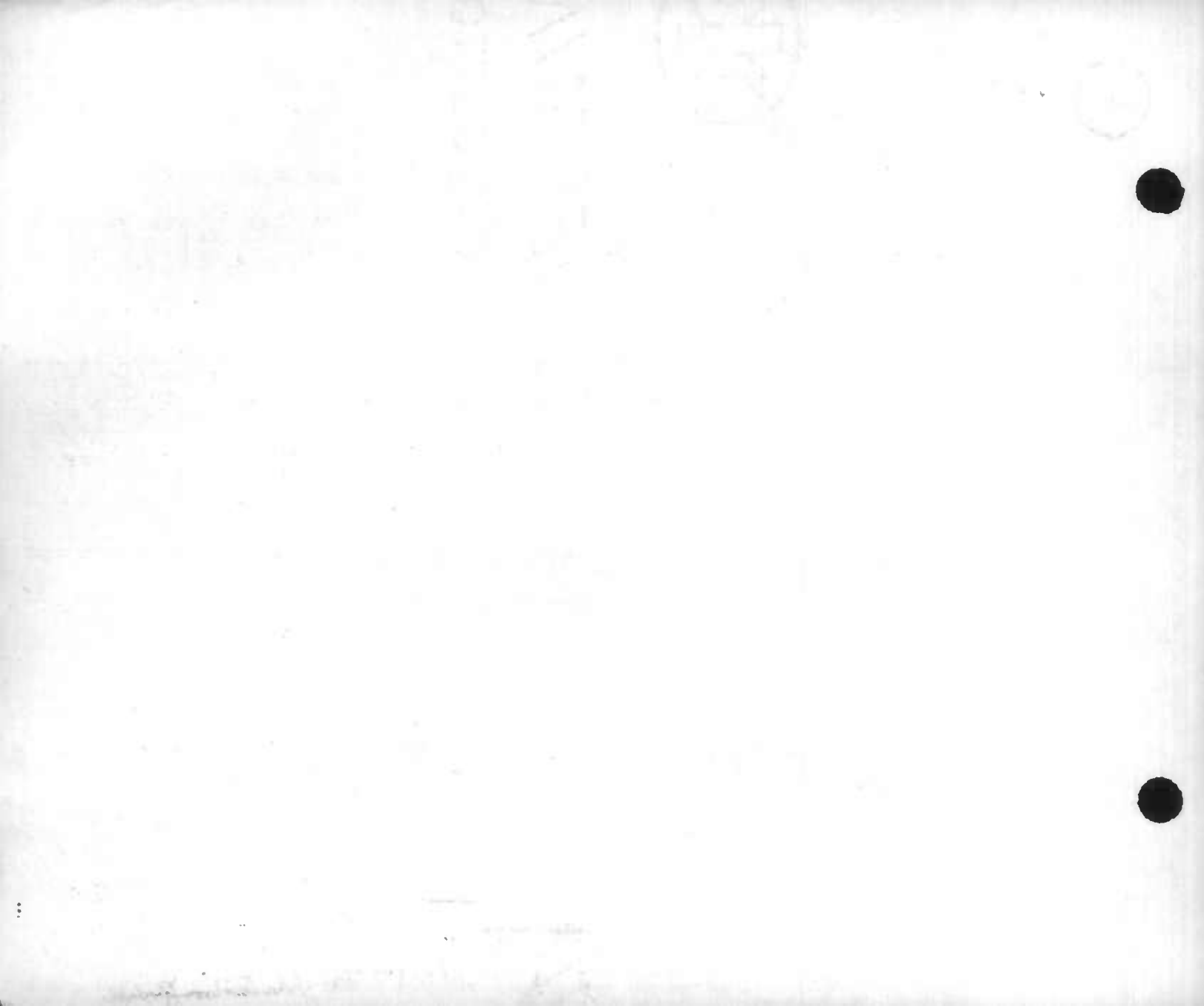
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Emily Lillian Banach			2a. DATE OF DEATH MONTH DAY YEAR April 7, 1984		2b. HOUR 10 am
3. SEX Female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR 4 14 23		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundle MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 835 Bay Ridge Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Md.	13b. COUNTY A.A.	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 835 Bay Ridge Ave. 21403	
14. FATHER'S NAME FIRST MIDDLE LAST Chester Thisselwood		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Thisselwood			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) NONE	17. INFORMANT ADDRESS Anthony Banach 835 Bay Ridge Ave.			
18. CAUSE OF DEATH (Enter only one cause per line, (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular Acc. Death</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>76</u> to 19 <u>84</u> , that (I) met last saw the deceased alive on <u>3/24</u> 19 <u>84</u> , and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I) attended (did not) view the body after death.					
22b. SIGNATURE <u>R. Hochman</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/5/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard T. Hochman, MD		22e. ADDRESS 16 Murray Ave, Annapolis, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4/13/84	23c. NAME OF CEMETERY OR CREMATOR NORTHWOOD	23d. LOCATION CITY OR TOWN COUNTY STATE Philadelphia Penn.		
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home 12 Ridgely Ave.		ADDRESS Annapolis Md.		25a. DATE REC'D. BY REGISTRAR APR 17 1984	25b. REGISTRAR'S SIGNATURE John Davidson

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 09055			
1. DECEASED NAME (TYPE OR PRINT) Sam Barres				2a. DATE OF DEATH MONTH DAY YEAR 04 08, 84				2b. HOUR 8:25am			
3. SEX Male		4. RACE Cau		5. DATE OF BIRTH MONTH DAY YEAR 12 01 14		6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH FEGM		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Community Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Navy			
13a. STATE MD		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Odenton		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 504A Placid Ct 21113			
14. FATHER'S NAME FIRST MIDDLE LAST Sam Frank				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Trumpe							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1936 - 1956		17. INFORMANT ADDRESS Mildred J. Barres 504 A Placid Ct. Odenton Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Right Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Malignant Hypertension Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 7 days			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 5 Apr 84, to 8 Apr 84, that (I) (we) lost saw the deceased alive on 8 Apr 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Gwenesta B. Melton				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 8 Apr-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GWENESTA B. MELTON, M.D.				22e. ADDRESS KACH, FEGM, MD 20755							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/11/1984		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Va.			
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home, Annapolis, MD 21401				24b. ADDRESS 263-2222		25. DATE REC'D BY REGISTRAR APR 10 1984					



Item #15 Film #G594

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09056

1- FOR STATE REGISTRAR
8/9/84 jp

REG. NO.

EDT

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MICHAEL (nmn) BEAROV			2a. DATE OF DEATH MONTH DAY YEAR APRIL 29 1984			2b. HOUR 1050 AM	
1. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 7, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Yellow Cab	

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1539 Florida Ave. 21144	
13a. STATE Maryland		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Severn		
14. FATHER'S NAME FIRST MIDDLE LAST Stanko Bearov			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Milka Mincin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. II 214-16-6715		17. INFORMANT (Wife) ADDRESS Mrs. Cathryn Bearov Same as # 13		

18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-sclerotic degeneration DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease		APPROXIMATE INTERVAL BETWEEN CAUSE AND DEATH Years	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Old myocardial infarction			
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19a. DATE OF OPERATION 6-29-84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Old myocardial infarction		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 65 4-29 84			

22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 8-29-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.	
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22b. SIGNATURE Hilary T. Overlund		DEGREE		22c. DATE SIGNED 8-29-84	
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) HILARY T. OVERLUND, M.D.		22e. ADDRESS 325 HOSPITAL DRIVE, #208 GLEN BURNIE, MARYLAND 21061	
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 1984		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Maryland	
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24. FUNERAL DIRECTOR NAME R. Monroe Jackson		25a. DATE REC'D. BY REGISTRAR MAY 1 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	
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Singleton Funeral Home, Glen Burnie, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

1900 - 1901

1901 - 1902

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1919 - 1920

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.				EST							
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
JOHN HENRY BIEN				APRIL 2, 1984				157 PM							
3. SEX MALE				4. RACE WHITE				5. DATE OF BIRTH MONTH DAY YEAR 9 5 1897				6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE, MD				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD			
10. CITY OR TOWN OF DEATH GLEN BURNIE				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PROJECTIONIST				12b. KIND OF BUSINESS OR INDUSTRY FED. GOV'T			
13a. STATE MARYLAND				13b. COUNTY ANNE ARUNDEL				13c. CITY OR TOWN PASADENA				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS 1670 TWICKENHAM ROAD 21122				14. FATHER'S NAME FIRST MIDDLE LAST JOHN HENRY BIEN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WILHELMINA SCHANTZ							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. 220.05.0812				17. INFORMANT LORETTA C. BIEN (same as 13e)				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumothorax, Ruptured</u> <u>1629</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Esophagus. Ca of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute heart failure</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>0</u>															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>4/2</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>H. Towhidian</u> 22c. DATE SIGNED				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAMID TOWHIDIAN, M. D.				22e. ADDRESS 3236 MOUNTAIN ROAD PASADENA, MARYLAND 21122											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 4/4/1984				23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT CEMETERY				23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD			
24. FUNERAL DIRECTOR NAME WALTER BROOKS BRADLEY, INC. BALTO., MD 21222				25a. DATE REC'D. BY REGISTRAR APR 3 1984				25b. REGISTRAR'S SIGNATURE <u>John Davidson</u>							

BP _____

22

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WAYNE R. BISHOP			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 19 84			2b. HOUR 1700		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 8-8-15	6. AGE (IN YEARS) LAST BIRTHDAY 18 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 19 84	2d. HOUR 1835	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK) (EPM, MSL, OF WORKING LIFE) Management Trainee		12b. KIND OF BUSINESS OR INDUSTRY Retail Sale
13a. STATE md.		13b. COUNTY A.A.Co.	13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 936 Digges Road		
14. FATHER'S NAME FIRST MIDDLE LAST Russel W. Bishop				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia L. Wyman				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-94-3260		17. INFORMANT ADDRESS Russell W. Bishpp # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chest Trauma - DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Slacked-up auto fell on chest DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:50 P.M. 4 19 84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Auto fell on lower anterior chest - was pinned			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY/TOWN COUNTY STATE 936 Digges Rd Crownsville AA Md			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE James E Wheeler			TITLE (SPECIFY) Dep			MEDICAL EXAMINER James E Wheeler		DATE SIGNED 4-19-84
EXAMINER'S NAME (TYPE OR PRINT) JAMES E WHEELER			ADDRESS 910 Primrose Rd Annapolis					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-23-84		23c. NAME OF CEMETERY OR CREMATORY Lakemont Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Davidsonville A.A. Md.		
24. FUNERAL DIRECTOR NAME ADDRESS T.A. Hardesty Annapolis Md. 21401			25a. DATE REC'D. BY REGISTRAR APR 25 1984					
			25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

1

MEMORANDUM
TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

[illegible text]

[illegible text]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										9 0 5 9 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Earl Lawrence Bond Sr.										2a. DATE KNOWN OF DEATH ESTI- MATED 4 7 1984										2b. HOUR M	
3. SEX M		4. RACE Can		5. DATE OF BIRTH MONTH DAY YEAR 3 13 41		6. AGE (IN YEARS) LAST BIRTHDAY 43 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD 4 7 1984		2d. HOUR M 0807							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.									
10. CITY OR TOWN OF DEATH Glen Burnie				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PYLE Driver				12b. KIND OF BUSINESS OR INDUSTRY Construction									
13a. STATE Md.				13b. COUNTY AA.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21061 1641 Marley Avenue											
14. FATHER'S NAME FIRST MIDDLE LAST Leonard BOND						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Garnetta George															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				(IF YES, GIVE WAR OR DATES) None		16b. SOCIAL SECURITY NO. 218-36-6050		17. INFORMANT ADDRESS Barbara Bond SAME AS 13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cardiopulmonary Arrest. Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE William P. Jones, M.D.								TITLE (SPECIFY) Deputy MEDICAL EXAMINER				DATE SIGNED 4/7/84									
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.								ADDRESS 695 America Ct Davidsonville, 21035													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4-10-84		23c. NAME OF CEMETERY OR CREMATORY Meadow Ridge Mem. PK				23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge Howard MD.											
24. FUNERAL DIRECTOR NAME McCall's Funeral Home				ADDRESS 237 E Patapsco Ave Balt MD 21225				25a. DATE REC'D. BY REGISTRAR APR 12 1984		25b. REGISTRAR'S SIGNATURE Julian Davidson											

MEDICAL CERTIFICATION

INSTRUCTIONS TO THE JURY

Case No. 100-100000-0000

State of Tennessee

County of Davidson

vs. The People

George

George

George

George

George

George



George

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

090600

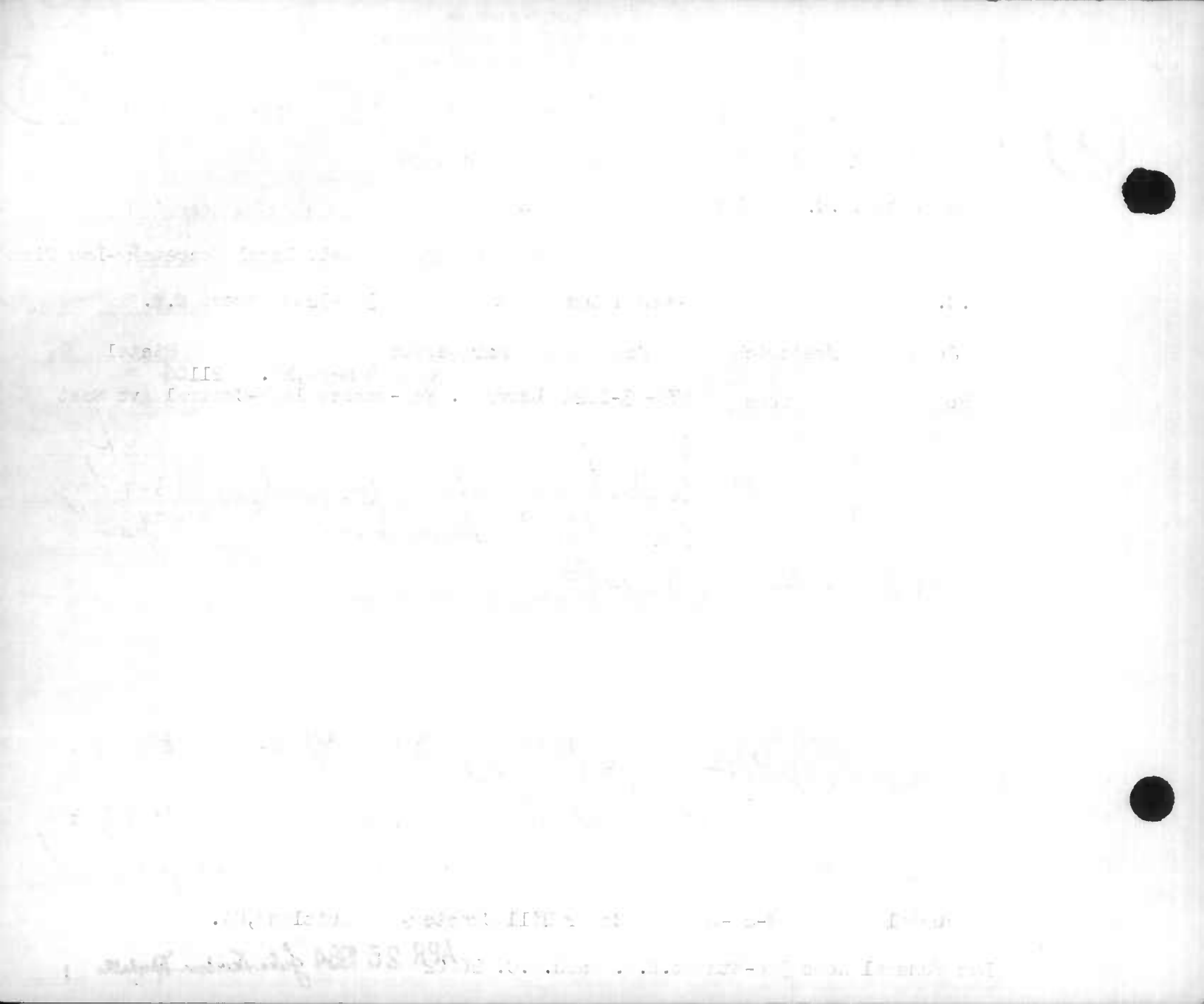
1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Emilie Fey Bonifant			2a DATE OF DEATH MONTH DAY YEAR April 23, 1984			2b HOUR 4:57 PM	
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR February 11 1904		6 AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 80 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10 CITY OR TOWN OF DEATH Annapolis		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Legal Secretary-Law Firm	
13a STATE D.C.		13b COUNTY <input checked="" type="checkbox"/>		13c CITY OR TOWN Washington		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST John Frederick Fey		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marguerite Kietel		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b SOCIAL SECURITY NO. 579-03-1826		17 INFORMANT ADDRESS Box #94 Mayo, Md. 21106 Leroy W. Fey-nephew 1407-Central Ave East					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4349 IMMEDIATE CAUSE (a) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Infarction = P. paralysis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized atherosclerosis APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk 3-4 day Yes-							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 4) Dementia 5) CHF							
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 4/1/80 19 84 , to 4/23 19 84 , that (I) (we) lost 2) 4/22 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Joseph N. Friend M.D.				DEGREE M.D.		22c DATE SIGNED 4/23/84	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Joseph N. Friend				22e ADDRESS 205 Ridgely Ave Annapolis, Md.			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 4-26-84		23c NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.	
24 FUNERAL DIRECTOR NAME Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002				25 DATE REC'D. BY REGISTRAR APR 26 1984			
25b REGISTRAR'S SIGNATURE J. Davidson-Randall							

BP
DHMH: 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09061

FOR
STATE
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN (nmn) BOOGAARD JR			2a. DATE OF DEATH MONTH DAY YEAR APRIL 22, 1984			2b. HOUR 1230 AM						
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 12, 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.						
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF BUSINESS, INDUSTRY, OR SERVICE) Appliance Serviceman		12b. KIND OF BUSINESS OR INDUSTRY C&E Service				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland			13b. COUNTY Anne Arundel		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 504 Dogwood Dr. S.W. 21061			
14. FATHER'S NAME FIRST MIDDLE LAST John Boogaard, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Zweedyk			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No N/A			16b. SOCIAL SECURITY NO. 385-09-4343		17. INFORMANT (Wife) ADDRESS Mrs. Dorothy M. Boogaard Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 11629 IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>LUNG CANCER</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE FRED T. KAHN, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/22/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 7575 RITCHIE HIGHWAY, S.E. GLEN BURNIE, MARYLAND 21061									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE April 22 1984		23c. NAME OF CEMETERY OR CREMATORY Security Process Inc.			23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto. Md.				
24. FUNERAL DIRECTOR NAME R. H. Hopkins			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE APR 24 1984						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09062

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME FIRST MIDDLE LAST PAUL F. BORDEN			2a. DATE OF DEATH MONTH DAY YEAR 4 7 84			2b. HOUR P.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 - 8 - 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH HUNNE HUNDEL MD.	
10. CITY OR TOWN OF DEATH CROFTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1583 ETON WAY				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. NAVY	
12b. KIND OF BUSINESS OR INDUSTRY RET. CAPT.		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE M.D.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE 1583 ETON WAY 21114	
14. FATHER'S NAME FIRST MIDDLE LAST EMMET BORDEN		15. MOTHER'S M maiden name FIRST MIDDLE LAST HELEN HARRINGTON		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			
16b. SOCIAL SECURITY NO. 579-09-8908		17. INFORMANT CORNELIA OFFETT BORDEN #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) Prostatic Cancer ± metastasis DUE TO, OR AS A CONSEQUENCE OF (b) at 10:15 pm DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE George W. Hu.		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/8/84	
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS 16 MURRAY AVE					
23c. BURIAL, CREMATION, REMOVAL Burial		23d. DATE 4/11/84		23e. NAME OF CEMETERY OR CREMATORY Arlington Natl.		23f. LOCATION Arlington County Va.	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel		ADDRESS Baltimore, Md.		25. DATE REC'D. BY REGISTRAR APR 11 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09063

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lou Ellen Bowen			2a. DATE OF DEATH MONTH DAY YEAR 4 29 84		2b. HOUR 1825 M
3. SEX Female	4. RACE CAU	5. DATE OF BIRTH MONTH DAY YEAR 10 6 07	6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.		
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel Gen.		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Retired	12b. KIND OF BUSINESS OR INDUSTRY Grocery	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.	13b. COUNTY AA. Deale Beach	13c. CITY OR TOWN AA. Deale Beach	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 958 MAIN ST 20751	
14. FATHER'S NAME FIRST MIDDLE LAST John Stevens		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Jones			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 240-07-0091		17. INFORMANT Ruth Rolin ADDRESS 1507 Fullers Cross Rd Winter Garden, Florida 32787	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) CARDIAC Arrest DUE TO, OR AS A CONSEQUENCE OF (b) ASCUD DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1 Sept 82 to 29 Apr 84 , that (I) (we) last saw the deceased alive on 8-10-83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William P. Jones, MD		DEGREE MD		22c. DATE SIGNED 30 Apr 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William P. Jones, MD		22e. ADDRESS 4837 Solomons Isl Rd 20711			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-4-84		23c. NAME OF CEMETERY OR CREMATORY Korners Grove Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Surry County, North Carolina					
24. FUNERAL DIRECTOR NAME Marzullo Funeral Service		ADDRESS Reisterstown, Md.		25a. DATE REC'D. BY REGISTRAR MAY 3 1984	
				25b. REGISTRAR'S SIGNATURE Lelia Davidson-Randall	



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09064

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) John Edwin Boyer, Sr.			2a. DATE OF DEATH MONTH DAY YEAR April 18, 1984			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 22, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
12. CITY OR TOWN OF DEATH Linthicum		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 290 Church Circle				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Field Coordinator		15. KIND OF BUSINESS OR INDUSTRY MD. State - AFL-CIO	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY A.A.		13c. CITY OR TOWN Linthicum		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST John W.S. Boyer			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl R. Frantz			16. STREET ADDRESS / ZIP CODE 290 Church Circle 21090			
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			18. SOCIAL SECURITY NO. W.W.II 219/16/2076		19. INFORMANT (Wife) Mrs. Connie R. Boyer			20. ADDRESS Same as #13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

1533

IMMEDIATE CAUSE (a) TERMINAL ACIDOSISAPPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2 days

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) UREMIA 20 to obstruction

4 months

DUE TO, OR AS A CONSEQUENCE OF

(c) Carotid artery bifurcation & MERS.

4.981

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: —

MEDICAL CERTIFICATION

19a. DATE OF OPERATION Feb 83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca colon		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (myself) attended the deceased from <u>9/29</u> , 19 <u>70</u> , to <u>4. 6</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>—</u> , 19 <u>—</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
27b. SIGNATURE Albert Nahum		27c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				27d. DATE SIGNED 4/18/84	
27e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Albert Nahum		27f. ADDRESS 100 North Broadway - Baltimore, Md					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 21, 1984		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Brooklyn Park A.A.		23d. LOCATION CITY OR TOWN COUNTY STATE Md	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home Glen Burnie, Md				25a. DATE REC'D. BY REGISTRAR APR 19 1984		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



UNITED STATES DEPARTMENT OF THE INTERIOR

BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

REPORT

NO.

DATE

BY

FOR

TITLE

PROJECT

LOCATION

STATE

PROJECT NO.

PROJECT NAME

PROJECT LOCATION

PROJECT STATE

PROJECT NO.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the cause must be specified at once.

BP

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09063

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dewey Iva Bracey			2a. DATE OF DEATH MONTH DAY YEAR April 2 1984			2b. HOUR PM			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR JUNE 6, 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NC		7c. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co., MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Annapolis Convalescent Ctr				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Rel Acc F Office Civil Service		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY A.A. 13c. CITY OR TOWN Riva			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2107 Cedar Drive 21140				
14. FATHER'S NAME FIRST MIDDLE LAST Phillip McGirt			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Mitchell			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-245104			
17. INFORMANT ADDRESS Dorcyce Globus - Same as #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Aspiration Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Venous Occlusion DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 30 April 1984 to 2 April 1984 , that (I) was lost saw the deceased alive on 30 April 1984 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.									
22b. SIGNATURE Jon B. Lowe			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 2 April 1984			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jon B. Lowe			22e. ADDRESS 77 West St Suite 210 Camp						
23a. BURIAL, CREMATION, REMOVAL (RECRY) Burial			23b. DATE 4/4/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Switland PG MD		
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD			ADDRESS		25a. DATE REC'D. BY REGISTRAR APR 4 1984		25b. REGISTRAR'S SIGNATURE [Signature]		

MEDICAL CERTIFICATION

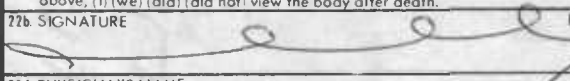

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JEREMIAH M. BRANDT				2a. DATE OF DEATH MONTH DAY YEAR APRIL 21, 1984			
1. SEX Male				2b. HOUR 2:00 A.M.			
3. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 16 93		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. CITIZEN OF WHAT COUNTRY? U.S.		7b. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fitting		12b. KIND OF BUSINESS OR INDUSTRY Shipbuilding	
13a. STATE Md.				13b. COUNTY AA		13c. CITY OR TOWN Glen Burnie	
14. FATHER'S NAME FIRST MIDDLE LAST George W. Brandt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Ammer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. 212-07-7283		17. INFORMANT Mrs. Emma Brandt - Same as #13.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) acute Renal Edema.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Renal failure							
DUE TO, OR AS A CONSEQUENCE OF (c) Ischemic Heart Disease.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 20, 84 , to 4/21/84 , 19 84 , that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 				22c. DATE SIGNED 4/21/84.			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DALJIT S. SAWHNEY, M.D.				22e. ADDRESS GLEN BURNIE, MD. 21061 7422 BALTIMORE-ANNAPOLIS BLVD..			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 2/21/84		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				25a. DATE REC'D. BY REGISTRAR APR 27 1984			
				25b. REGISTRAR'S SIGNATURE 			

1958

(A)

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09067

1. DECEASED NAME (TYPE OR PRINT)		FIRST Lillian		MIDDLE V.		LAST Brewer		2a. DATE OF DEATH MONTH DAY YEAR April 4, 1984				2b. HOUR 3:00 PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 16, 1934				6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.				IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Household	
13a. STATE Md.		13b. COUNTY A.A.		13c. CITY OR TOWN Severn		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 7918 Clark Station Rd. 21144					
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. ----- 216-24-0774		17. INFORMANT George Brewer 13e							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Respiratory Arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>years</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 hours	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Fracture right hip</u>													
19a. DATE OF OPERATION 4/3/84		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Fracture hip</u>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 4 1 1984		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <u>Fall</u>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <u>Home</u>		21f. LOCATION STREET <u>4/4/84</u>		CITY OR TOWN <u>4/4/84</u>		COUNTY <u>4/4/84</u>		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/4/84</u> to <u>4/4/84</u> that (I) (we) last saw the deceased alive on <u>4/4/84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (I) (we) did not view the body after death.													
22b. SIGNATURE <u>[Signature]</u>		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/6/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SCOTT DECKER		22e. ADDRESS 325 Hospital Dr Glen Burnie Md 21061											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-7-84		23c. NAME OF CEMETERY OR CREMATORY Ft. LINCOLN				23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Md.					
24. FUNERAL DIRECTOR NAME ADDRESS T.A. Hardesty Annapolis Md. 21401				25a. DATE REC'D. BY REGISTRAR APR 6 1984		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death within the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows injury or other traumatic event, the medical examiner must be notified at once.

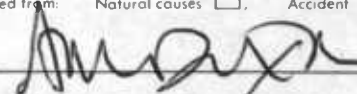
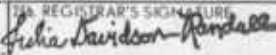
Received Glen Burnie Md 4/6/84 AA City

BP

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Thomas Richard Brown										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH 4 DAY 30 YEAR 84										2b. HOUR 6:55			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH 1 DAY 13 YEAR 56		6. AGE (IN YEARS) LAST BIRTHDAY 28 YRS.		IF UNDER 1 YR. MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		2c. DATE PRONOUNCED DEAD 4 30 84										2d. HOUR a	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD											
10. CITY OR TOWN OF DEATH Annapolis				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 408-A Boston Heights								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE MARYLAND				13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS 408 A Boston Heights Circle													
14. FATHER'S NAME FIRST EDWARD MIDDLE BROWN LAST BROWN						15. MOTHER'S MAIDEN NAME FIRST LILLIAN MIDDLE COLBERT LAST COLBERT																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO						16b. SOCIAL SECURITY NO.		17. INFORMANT DALE BROWN ADDRESS Annapolis, Md. 21401 418 A Bostson Heights Circle															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9551 IMMEDIATE CAUSE (a) Shotgun wound to head DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 4 30 1984				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) Self inflicted															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET 408-A Boston Hgts, Annapolis, A.A. CO., Md. CITY OR TOWN ANNAPOLIS COUNTY A.A. STATE MD															
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 4/30/84									
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.				ADDRESS 111 Penn St. Balto., MD.																			
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 5-4-1984		23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK				23d. LOCATION CITY OR TOWN Annapolis COUNTY A.A. STATE Maryland													
24. FUNERAL DIRECTOR NAME Annopolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A.										25a. DATE REC'D. BY REGISTRAR MAY 7 1984						REGISTRAR'S SIGNATURE 							

STATE OF NEW YORK
IN SENATE
JANUARY 11, 1906

102

102

REPORT OF THE

COMMISSIONER

OF THE LAND OFFICE

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OFFICE OF THE
COMMISSIONER OF THE
LAND OFFICE

NEW YORK

PRINTED BY THE

STATE OF NEW YORK

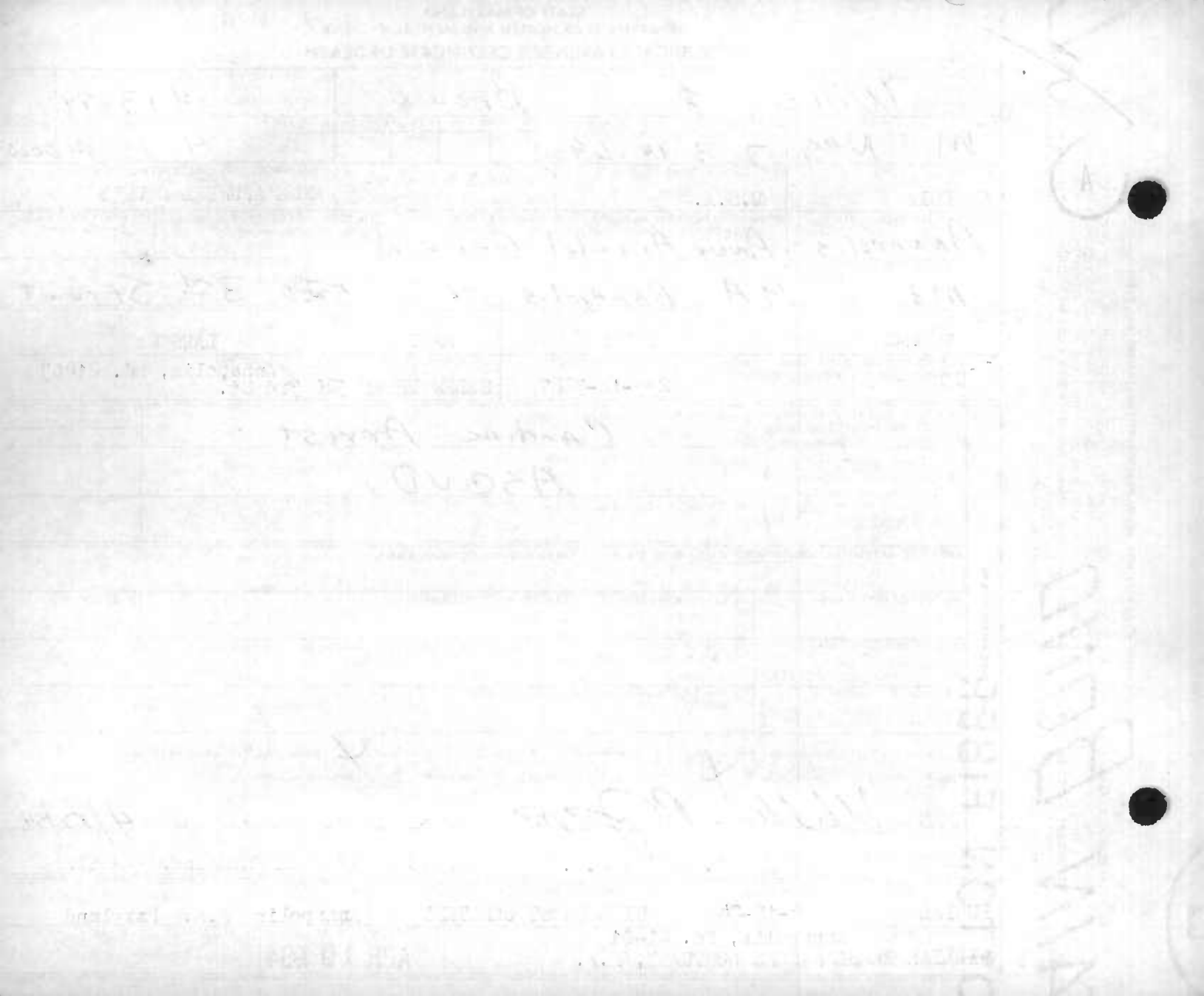
1906

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Willie Brown							2a. DATE KNOWN OF DEATH ESTIMATED 4 13 1984		2b. HOUR 0028		
3. SEX M	4. RACE Neg	5. DATE OF BIRTH MONTH 7 DAY 3 YEAR 14	6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS.	IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN.	IF UNDER 24 HRS. MONTHS 0 DAYS 0 HOURS 0 MIN.	7c. DATE PRONOUNCED DEAD 4 13 1984	2d. HOUR 0028				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY					
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 520 3rd Street			
14. FATHER'S NAME FIRST THOMAS MIDDLE BROWN LAST BROWN				15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE LAWSON LAST LAWSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 255-12-3887		17. INFORMANT ADDRESS Annapolis, Md. 21403 HELEN BROWN 520 3rd St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE William P. Jones				TITLE (SPECIFY) Deputy M.D.				MEDICAL EXAMINER DATE SIGNED 4/12/84			
EXAMINER'S NAME (TYPE OR PRINT) william P. Jones, M.D.				ADDRESS 695 America Ct Davidsonville 21035							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 4-18-84		23c. NAME OF CEMETERY OR CREMATORY HILL CREST CEMETERY		23d. LOCATION CITY OR TOWN Annapolis A.A. COUNTY Maryland STATE			
24. FUNERAL DIRECTOR NAME Annapolis, Md. 21401 WILLIAM REESE & SONS MORTUARY, P.A.						25a. DATE REC'D. BY REGISTRAR APR 19 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09070

1- FOR
STATE
REGISTRAR

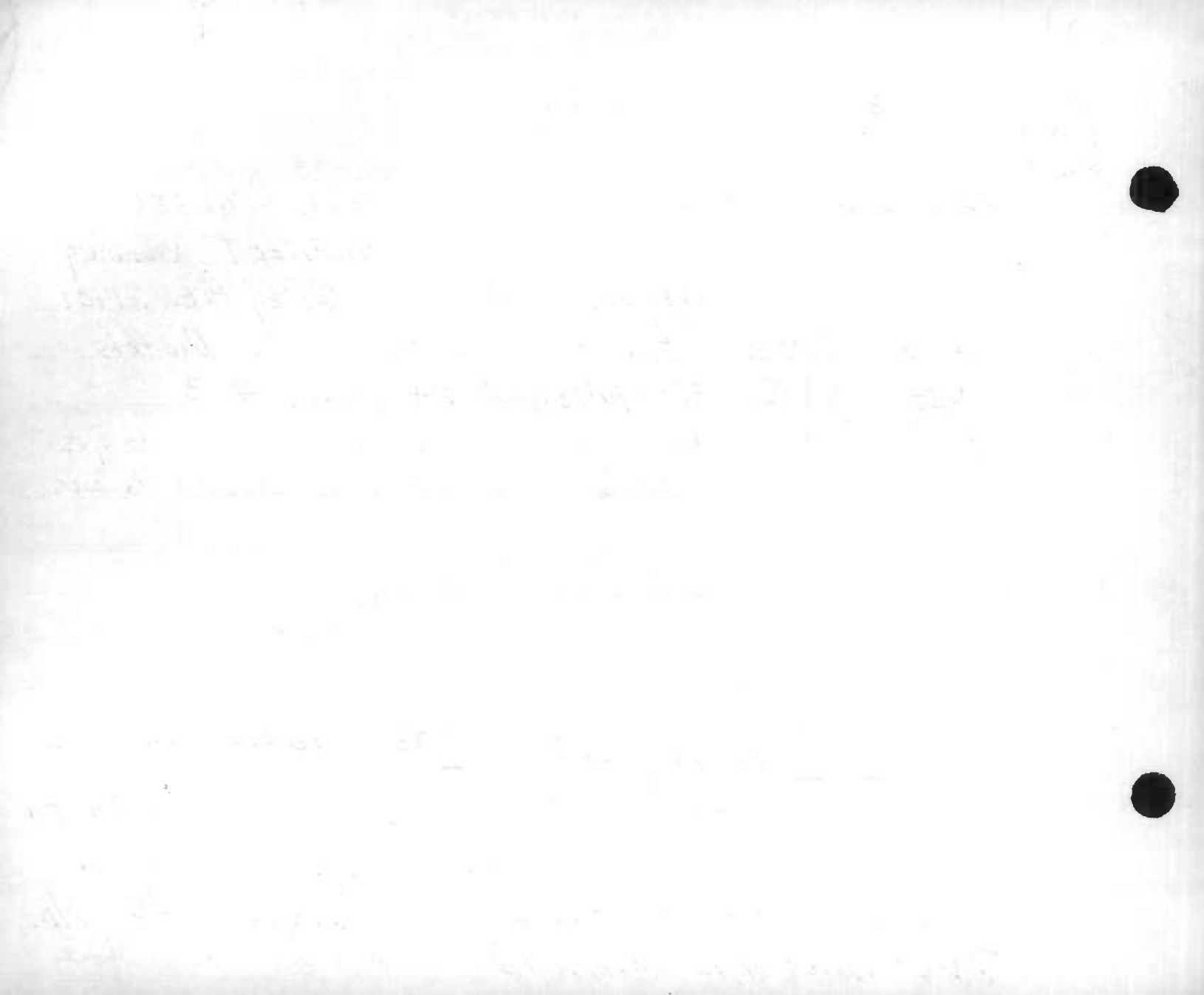
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) JAMES WOOD Burch			2a. DATE OF DEATH MONTH DAY YEAR 4/10/84			2b. HOUR 1840 hrs.			
3 SEX MALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 11/20/21		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AA&H				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ARCHITECT		12b. KIND OF BUSINESS OR INDUSTRY Building	
13a. STATE MD		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 6 TANNEY AVE 21401	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES WOOD BUREH				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELSIE VICKERS					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES WWII				16b. SOCIAL SECURITY NO. 579-096398		17. INFORMANT ADDRESS ELIZABETH R. BURCH #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA, COLON DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA METASTATIC TO LIVER DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 yrs. 6 mos.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from OCT 83 , to 10 APR 84 , that (I) was lost saw the deceased alive on 10 APR 84 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did) not view the body after death.									
22b. SIGNATURE Michael N. Peters						DEGREE MD		22c. DATE SIGNED 10 APR 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL N. PETERS						22e. ADDRESS 2510 RIVA RD ANNAPOLIS, MD			
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) BURIAL			23b. DATE 4/13/84		23c. NAME OF CEMETERY OR CREMATORY St. Annes		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS AA MD.		
24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel Annapolis, Md.						25a. DATE REC'D. BY REGISTRAR APR 11 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

MEDICAL CERTIFICATION

29

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 18 per letter 4/12/84 dad				STATE OF MARYLAND		092711			
FOR 1- STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				EST	
1. DECEASED NAME				2a. DATE OF DEATH		3. SEX		4. RACE	
FIRST MIDDLE LAST (TYPE OR PRINT) BERTHA B BURNS				MONTH DAY YEAR APRIL 1, 1984		M		1048 PM	
5. DATE OF BIRTH				6. AGE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	
MONTH DAY YEAR January 3, 1911				IN YEARS LAST BIRTHDAY 73		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH				12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS	
ANNE ARUNDEL COUNTY MD.				HOMEMAKER		Own Home		727 213th. Street 21122	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS	
GLEN BURNIE				NORTH ARUNDEL HOSPITAL		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		727 213th. Street 21122	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST Norman Guinn				FIRST MIDDLE LAST (Unknown)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> (IF YES, GIVE WAR OR DATES)		218-22-4432	
17. INFORMANT				18. CAUSE OF DEATH		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
ADDRESS Mr. Frank Burns (Husband) Same as 13c.				PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Coronary Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a				21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. LOCATION	
				WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME	
				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		7845 OAKWOOD ROAD	
				IRA E. KAPLAN, M.D.		GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial				4/4/84		Glen Haven Mem. Park		Glen Burnie Anne Arundel Md.	
24. FUNERAL DIRECTOR				25. DATE REC'D. BY REGISTRAR		25a. REGISTRAR'S SIGNATURE		25b. REGISTRAR'S SIGNATURE	
Mc Cully Funeral Home of Pasadena Mountain and Tick Neck Rds. Pasadena, Md. 21122				APR 3 1984		C. Davidson-Rendall			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09072

1- FOR
STATE
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LUCILLE L. CALHOUN			2a. DATE OF DEATH MONTH DAY YEAR APRIL 23, 1984			2b. HOUR 215 AM	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 7 25 15		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
						12b. KIND OF BUSINESS OR INDUSTRY	

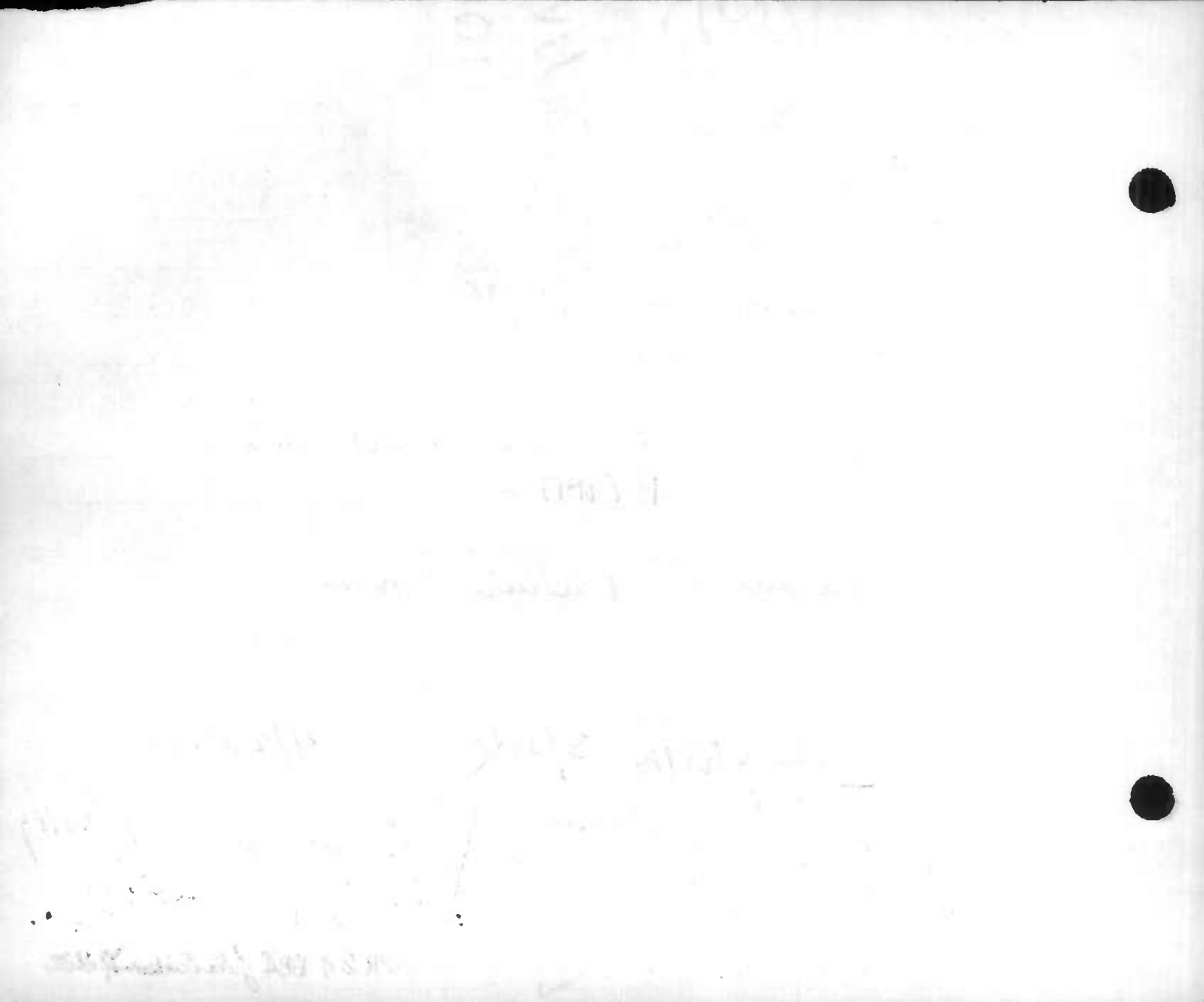
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY AnneArundel		13c. CITY OR TOWN Glenburnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 112 Country Club Drive 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Oscar Logan			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mariah Woodson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-20-6377		17. INFORMANT ADDRESS Shirley Hines 112 Country Club Drive					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>HTN -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pneumonia - Tubercular Disease</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/31/84</u> 19 <u>84</u> to <u>4/23/84</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>4/22/84</u> 19 <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>Dr. Jorge B. Ramirez</u> DEGREE JORGE B. RAMIREZ, M.D.				22c. DATE SIGNED <u>4/23/84</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT)				23b. ADDRESS 7845 OAKWOOD ROAD, SUITE 205 GLEN BURNIE, MARYLAND 21061			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 4/25/84		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.	
24. FUNERAL DIRECTOR NAME Wm C March F/R Inc. 1101 E North Avenue				25a. DATE REC'D. BY REGISTRAR APR 24 1984			
				25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09073

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GERIE R. CARTER			2a. DATE OF DEATH MONTH DAY YEAR 4 9 84			2b. HOUR M M	
1. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 4 7 98		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH EDGEWATER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PLEASANT LIVING NURSING HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE MARYLAND		13b. COUNTY A.A.		13c. CITY OR TOWN CHURCHTON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MILES CARTER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANE YOUNG		17. STREET ADDRESS / ZIP CODE 1037 Franklin Manor Rd. 20733			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W.I		17. INFORMANT ADDRESS DORA CARTER 1037 Franklin Manor Rd. Churchton, Md. 20733			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Pulmonary Embolus**

DUE TO, OR AS A CONSEQUENCE OF

4360
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.(b) **HE CVA**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 Hrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct 19 76 , to 4/9 19 84 , that (I) have lost saw the deceased alive on April 4 19 84 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was (did not) view the body after death.							
22b. SIGNATURE Harry J. Steinfeld		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/11/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) STEINFELD		22e. ADDRESS 6131 SHADYSIDE RD, SHADYSIDE MD 20764					

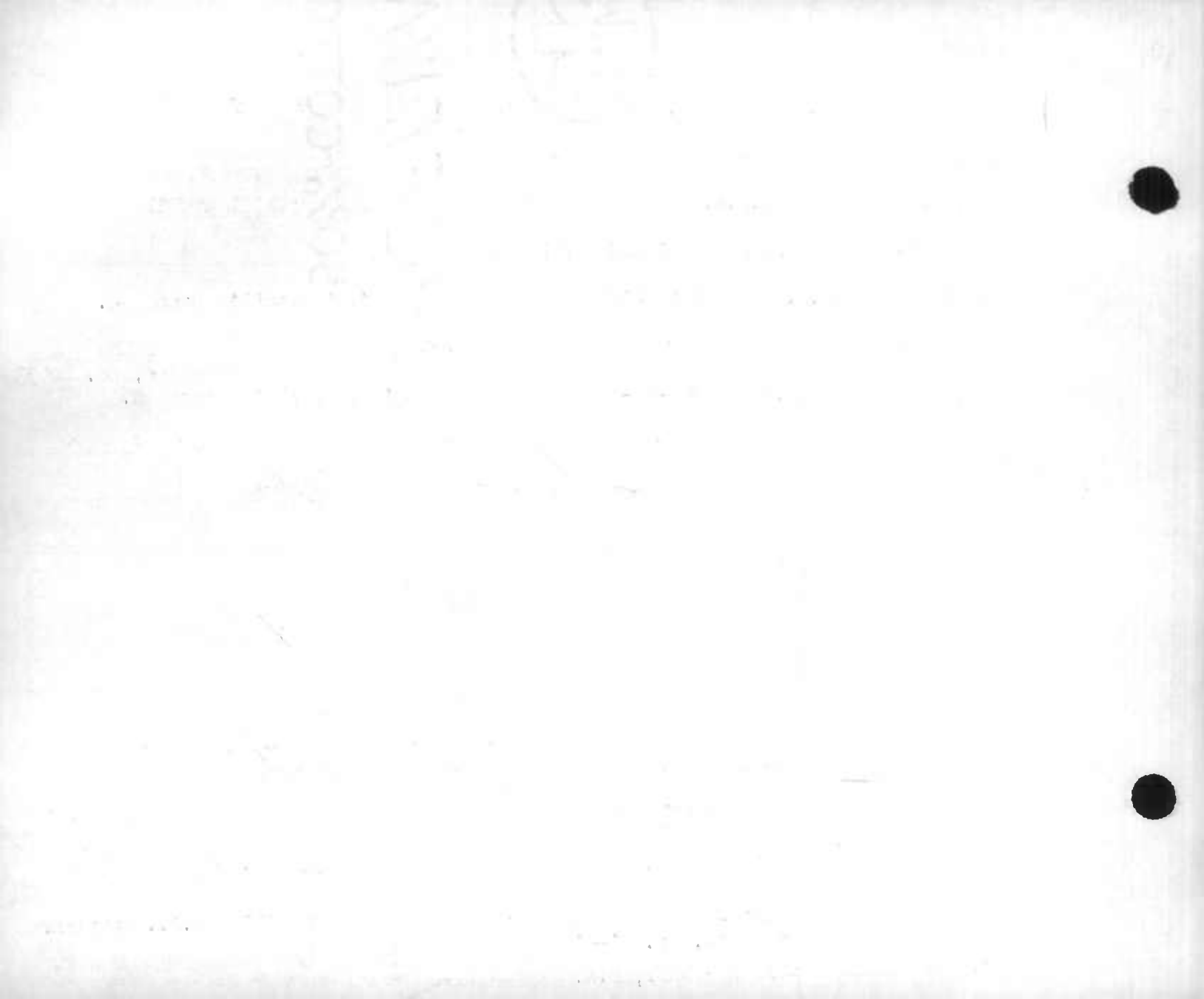
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 4-13-84		23c. NAME OF CEMETERY OR CREMATORY OUR LADY OF SORROWS		23d. LOCATION CITY OR TOWN COUNTY STATE Owensville A.A. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS WILLIAM REESE & SONS MORTUARY, P.A. Annapolis, Md. 21401				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 13 1984 Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
EMMA M. CATTERTON					MONTH DAY YEAR HOUR 4 6 54 6 35 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE		WHITE		MONTH DAY YEAR 12 7 1891		92 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.				ANNE ARUNDEL MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Brooklyn Pk.		MERIDIAN HAMMONDS LANE				Homemaker		---	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Baltimore		Arbutus		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		5519 Oregon Avenue 21227	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Unknown Westenhofer					FIRST MIDDLE LAST Katherine Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
NO					212-74-7058		Alvin F. Catterton 5519 Oregon Ave. 21227		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>cardiac arrest</u>									
4292 DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Arteriosclerosis</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>Cardiovascular disease</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-6-84</u> , to <u>4-6-84</u> , that (I) (we) last saw the deceased alive on <u>4-6-84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					DEGREE		22c. DATE SIGNED		
<u>[Signature]</u>					MD				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
SEENI VAPAR					606 Hammonds Lane, Bkto, 21225				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			4/9/84		Lorraine Park Cemetery		Woodlawn Baltimore Md.		
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Hubbard Funeral Home, Inc. 4107 Wilkens Avenue					APR 9 1984				

BP



20% COLLECTOR

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please return this certificate to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE						09075	
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST KIM KWONG CHENG				MONTH DAY YEAR 04 15 84		5 13 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		ASIAN		MONTH DAY YEAR 04 25 02		81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
KOREA		HONG KONG U.S.				ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
ANNAPOLIS		ANNE ARUNDEL GENERAL HOSPITAL		NONE		NONE	
13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
MD		ANNE ARUNDEL		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		ANNAPOLIS MD. 21401 130 HEARNE ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
TAI KUEN CHENG				TIAO SONG HSU			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
NO		—		SAN TSAI HSU - ABOVE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> <u>4292</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Mar. 6, 1984</u> to <u>Apr. 15, 1984</u> , that (I) (we) last saw the deceased alive on <u>Mar. 21, 1984</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not move the body after death.		22b. SIGNATURE <u>Charles J. Wu M.D.</u>		22c. DATE SIGNED <u>Apr. 15, 1984</u>		22d. PHYSICIAN'S NAME (TYPE OR PRINT)	
22e. ADDRESS 21061 7845 OAKWOOD ROAD GLEN BURNIE MARYLAND		22f. ADDRESS		22g. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Entombment		4/19/84		St. Agnes Cem. W. Baltimore		Chester P.	
24. FUNERAL DIRECTOR NAME ADDRESS		24b. ADDRESS		24c. DATE REC'D BY REGISTRAR			
Paul S. Baranec		Silver Spring MD		APR 18 1984 John P. Gordon			

APR 3 1991

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09076

REG. NO.

EDT

1. FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)FIRST
WALLACEMIDDLE
RUSSELLLAST
CHILDS

SR

2a. DATE OF DEATH

MONTH

DAY

YEAR

APRIL

29, 1984

2b. HOUR

625 AM

3. SEX

mal

4. RACE

white

5. DATE OF BIRTH

Feb. 14, 1912

6. AGE (IN YEARS LAST BIRTHDAY)

12

IF UNDER 1 YEAR

MONTHS DAYS

IF UNDER 24 HRS.

HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Maryland

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

ANNE ARUNDEL COUNTY

MD.

10. CITY OR TOWN OF DEATH

GLEN BURNIE

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Retired

12b. KIND OF BUSINESS OR INDUSTRY

Gas & Electric

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Maryland

13b. COUNTY

AA

13c. CITY OR TOWN

Millersville

13d. INSIDE CITY LIMITS?

YES ☐ NO ☒

13e. STREET ADDRESS / ZIP CODE

1646 Millersville Road 21108

14. FATHER'S NAME

Nathan

MIDDLE

Childs

LAST

Ida

15. MOTHER'S MAIDEN NAME

Ida

MIDDLE

Watson

LAST

Same as #13

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)

NO

16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)

-

16c. SOCIAL SECURITY NO.

212-65-4624

17. INFORMANT

Suzanne Gibbons Childs -

ADDRESS

Same as #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

DRAFT - RECAL JAILIN -

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 4/10/84, 19 to 4/28/84, 19, that (I) (we) last saw the deceased alive on 4/28/84, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If not, did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☒MEDICAL DIRECTOR ☐STAFF PHYSICIAN ☐

22c. DATE SIGNED

4/28/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

JORGE B. RAMIREZ, M.D.

22e. ADDRESS

7845 OAKWOOD ROAD, SUITE 205
GLEN BURNIE, MARYLAND 21061

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

Burial

23b. DATE

May 2, 1984

23c. NAME OF CEMETERY OR CREMATORY

Baldwin Memorial

23d. LOCATION

Millersville

COUNTY

AA

STATE

MD

24. FUNERAL DIRECTOR

Taylor Funeral Chapel - Annapolis, MD

25a. DATE REC'D. BY REGISTRAR

MAY 2 1984

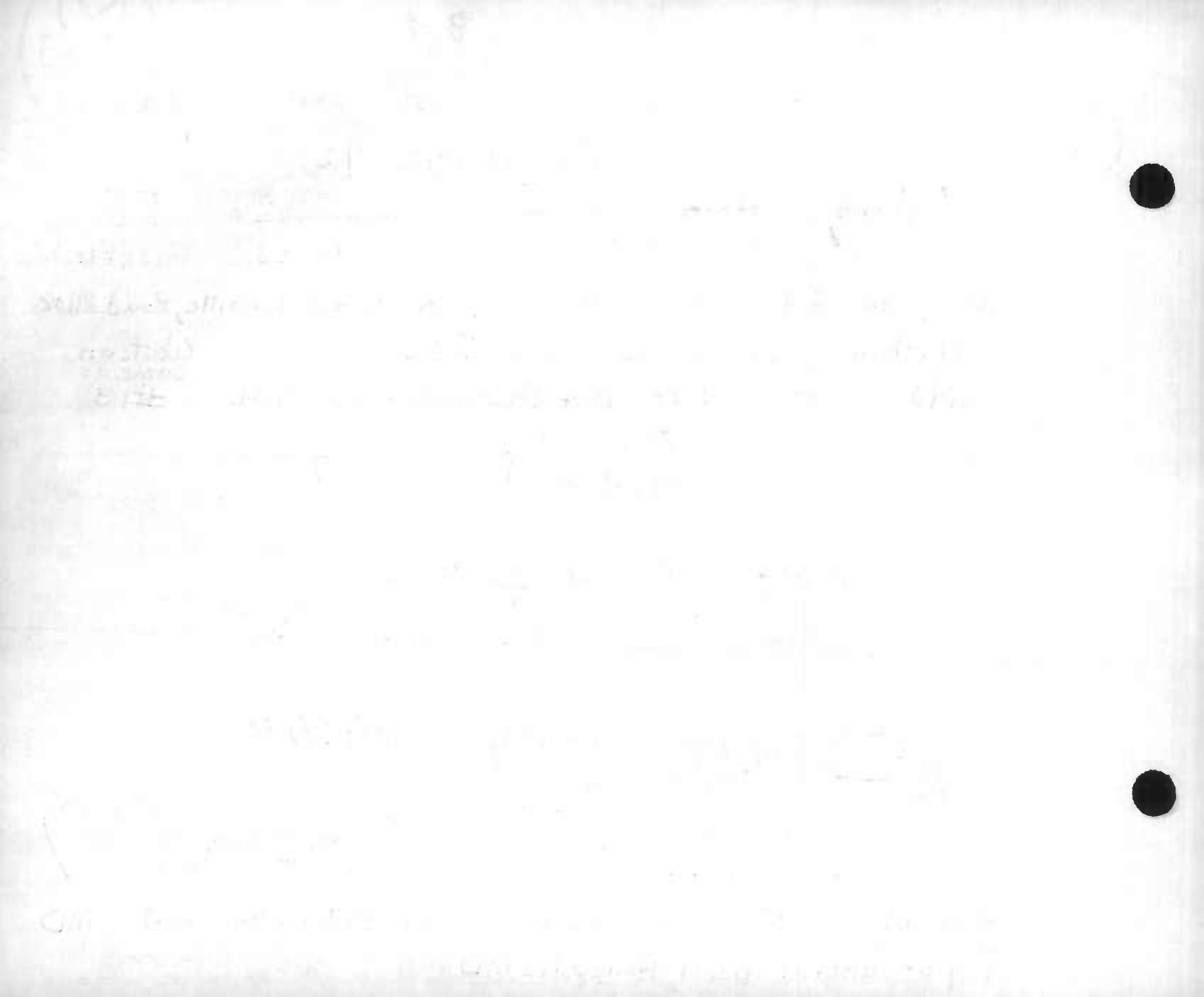
25b. REGISTRAR'S SIGNATURE

John Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove coronary papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				09077			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Martha Sarah CLARK				2a. DATE OF DEATH MONTH DAY YEAR April 2, 1984		2b. HOUR A M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 13, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.	
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 302 Benmere Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Elec. Assmb.		12b. KIND OF BUSINESS OR INDUSTRY Bendix	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13a. STATE Maryland		13b. CITY Balto.		13c. CITY OR TOWN Towson		13e. STREET ADDRESS / ZIP CODE 625 Dunkirk Road 21212	
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Wicker				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie August			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215.05.7984		17. INFORMANT Sister ADDRESS 302 Benmere Rd. Lillian A. Dyott Glen Burnie, MD			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) Diarrhea							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jose M. Presbitero MD.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/2/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose M. Presbitero MD				22e. ADDRESS 7845 Oakwood Road, Glen Burnie, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 5, 84		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. MD	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home ADDRESS Glen Burnie, MD				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE 1003 1984 Anderson-Rendell			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09078

FOR
1 - STATE
REGISTRAR

REG. NO.

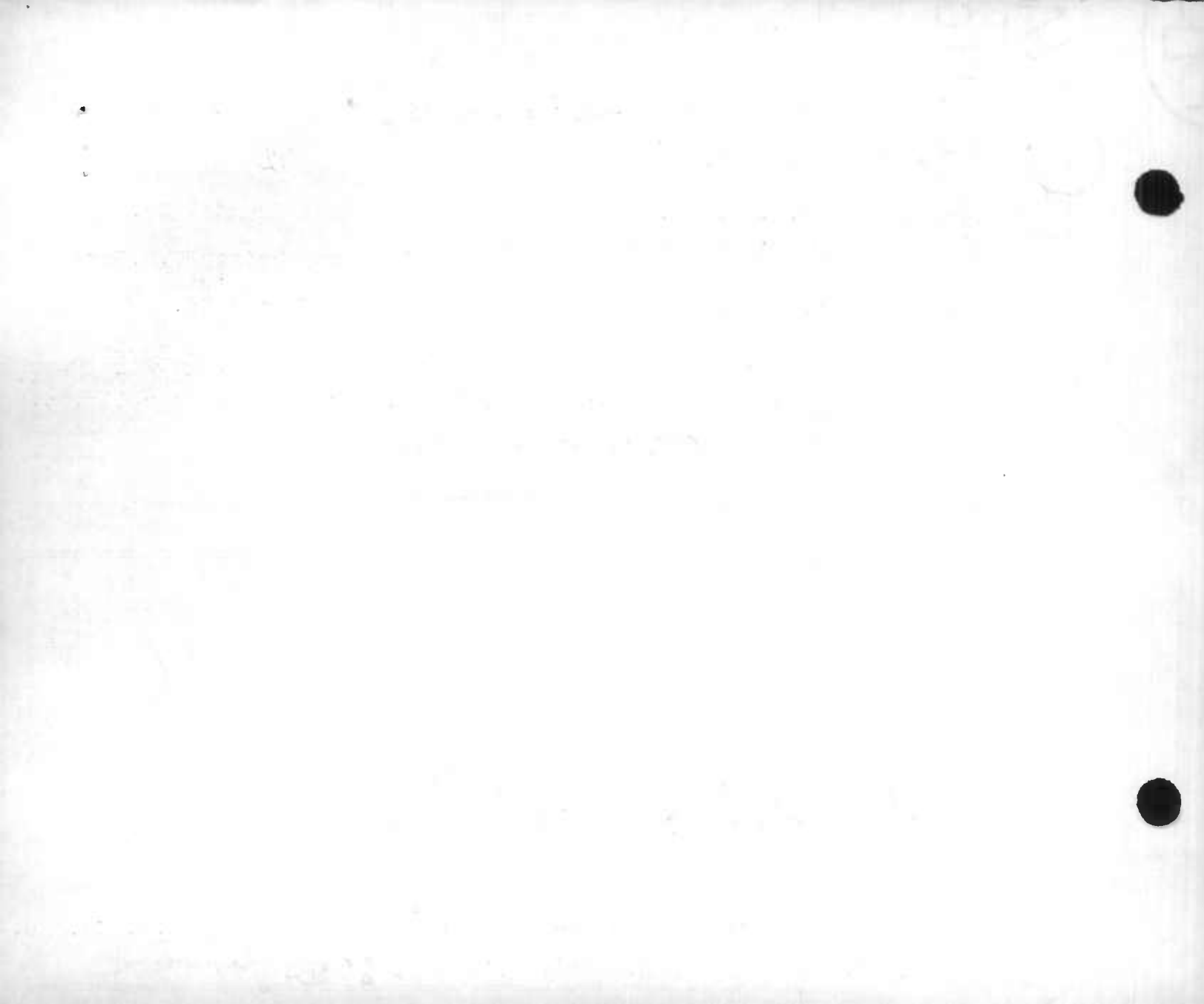
1. DECEASED NAME (TYPE OR PRINT) Helen Elizabeth Clements			2a. DATE OF DEATH MONTH DAY YEAR 4 21 84			2b. HOUR 11:25 A.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 1, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C. U.S.A.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) supervisor		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't		
13a. STATE Md.			13b. COUNTY A.A. Co.		13c. CITY OR TOWN Mayo		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 628 Mayo Rd. 21106	
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Norris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Burrows			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				
16a. SOCIAL SECURITY NO. no			17. INFORMANT ADDRESS Western Shores Est. William H. Norris Port Republic, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5579 IMMEDIATE CAUSE (a) mesenteric ischemia DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE H. Goldstein			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 4/24/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland A.A. Co. Md.			
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home			12. ADDRESS 12 Bidgely Ave. Annapolis, Md.			25a. DATE REC'D. BY REGISTRAR APR 25 1984				

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09079

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DENNIS FIRST MIDDLE LAST COLEMAN, JR.			2a. DATE OF DEATH MONTH DAY YEAR 4 12 84			2b. HOUR 1:00 PM	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 12 28 72		6. AGE (IN YEARS LAST BIRTHDAY) 11 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH SEVERNA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 331 JENNINGS RD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STUDENT		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY ANNE ARUNDEL 13c. CITY OR TOWN SEVERNA Pk.		14. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		15. STREET ADDRESS 331 JENNINGS RD.			
14. FATHER'S NAME FIRST MIDDLE LAST DENNIS COLEMAN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERNICE BROWN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO	
17. INFORMANT Enoch Bessick		ADDRESS 331 Jennings Rd.					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>HYPOXIA</u> <u>2040</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ANEMIA + DIFFUSE PNEUMONIA</u> (c) <u>ACUTE LYMPHOBLASTIC LEUKEMIA</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>2 WKS.</u> <u>3 1/2 YRS</u>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ECTHYMA @ ANTECUBITAL FOSSA - DUE TO ASPERGILLOSIS</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>5/9</u> , 19 <u>80</u> , to <u>4/12</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>4/10</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above.					
22b. SIGNATURE <u>Keith E. Luddy MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/12/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>KEITH E. LUDDY MD</u>		22e. ADDRESS <u>16. OF MD. HOSPITAL</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>4-17-84</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Sallis F.B. Church Cem</u>	
23d. LOCATION CITY OR TOWN COUNTY STATE <u>ANNE ARUNDEL CO. MD.</u>		25a. DATE REC'D. BY REGISTRAR <u>MAY 9 1984</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	
24. FUNERAL DIRECTOR NAME <u>BROWN-THOMPSON</u> ADDRESS <u>1913 W. BACOT ST.</u>					



[Faint, illegible handwriting on lined paper]

1- FOR
STATE
REGISTRAR

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
ALLYSON M. COLDER			4 7 19 84			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	7d. HOUR	
FEMALE	WHITE	07 27 45	38 YRS.			4 9 1984	11:40 a M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
MARYLAND		U.S.A.				Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Glen Burnie		North Arundel Hospital (DOA)				MEDICAL SECRETARY		HOSPITAL
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
MARYLAND			A.A.	GLEN BURNIE	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	1407 SCANLAN DRIVE, 21061		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
CHARLES E. MORGAN			VIRGINIA L. SMITH					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO			218-42-8684		ROBERT L. COLDER 1407 SCANLAN DRIVE GLEN BURNIE, MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Combined drug intoxication</u> 9505 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			HOUR A.M. MONTH DAY YEAR P.M. 4/ 19 84		self ingested			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
			highway		Md. Rt#10 New Ordinance Rd. Glen Burnie, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE			TITLE (SPECIFY)				DATE SIGNED	
Margarita A. Korell, M.D.			Assistant MEDICAL EXAMINER				4-10-84	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
			111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
CREMATION			04-14-84		LOUDON PARK		BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME			ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
HUBBARD FUNERAL HOME, INC.			4107 WILKENS AVE.		APR 13 1984			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09081

1- FOR
STATE
REGISTRAR

REG. NO.

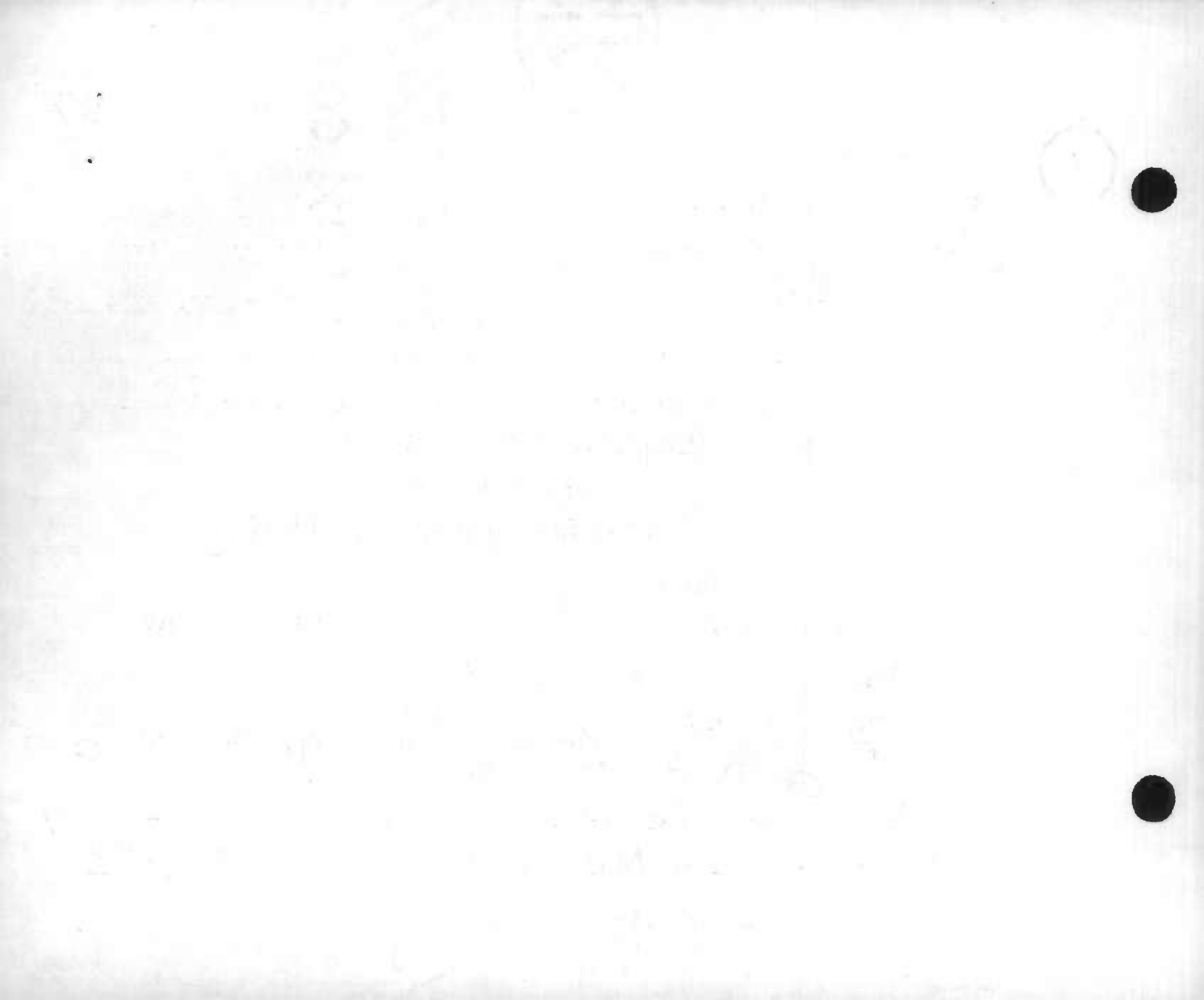
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ruth Leon Conway			2a. DATE OF DEATH MONTH DAY YEAR April 14. 1984		2b. HOUR 8:00 AM
3 SEX Female	4 RACE Cauc.	5 DATE OF BIRTH MONTH DAY YEAR 12/08/02	6 AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Clenton Tenn.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH A.A. MD.		
10 CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1081 Broadview Dr.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Cival Service
13a. STATE Md.	13b. COUNTY A.A.	13c. CITY OR TOWN Jessup	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE A 3 Clark Rd. 20794
14. FATHER'S NAME FIRST MIDDLE LAST J. R. White		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Cathcart			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE		17. INFORMANT ADDRESS 1081 Broadview Jane S. Brantley Annapolis Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Congestive heart failure 1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) severe anemia (c) bladder cancer with bleeding APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a none					
19a. DATE OF OPERATION N/A		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N/A		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) N/A	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT HOME <input checked="" type="checkbox"/> AT PLAY <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A N/A	
22a. I certify that (I) (this hospital) attended the deceased from MARCH 23 1984 to April 14 1984, that (I) (we) lost saw the deceased alive on April 2 1984, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Thomas M. Walsh MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-16-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS M. WALSH MD		22e. ADDRESS 269 Peninsula Farm Road Arnold Md 21012			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/16/84		23c. NAME OF CEMETERY OR CREMATORY George Washington	
23d. LOCATION CITY OR TOWN COUNTY STATE Delphi Md					
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home Annapolis Md. 21401		25a. DATE REC'D. BY REGISTRAR APR 17 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										7 0 8 2 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Donald Warren Cook						2a. DATE KNOWN OF DEATH ESTIMATED 4 10 19 84		2b. HOUR M			
3. SEX Male	4. RACE CAU	5. DATE OF BIRTH MONTH 12 DAY 9 YEAR 34	6. AGE (IN YEARS) LAST BIRTHDAY 49 YRS.	IF UNDER 1 YR. MONTHS DAYS 	IF UNDER 24 HRS. HOURS MIN. 	2c. DATE PRONOUNCED DEAD 4 10 19 84		2d. HOUR 0341 M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD					
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Steelworker		12b. KIND OF BUSINESS OR INDUSTRY Steel			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Md.		13b. COUNTY AA		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 309 Green Drive			
14. FATHER'S NAME FIRST Leon MIDDLE A. LAST Cook				15. MOTHER'S MAIDEN NAME FIRST Edna MIDDLE M. LAST Mills							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 3/52--		17. INFORMANT 309 Green Drive Pasadena, Md. 21122 Mrs. Katherine L. Cook					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Cardiac Arrest. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) minutes									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE William P. Jones		TITLE (SPECIFY) Deputy				MEDICAL EXAMINER		DATE SIGNED 4/10/84			
EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D.		ADDRESS 695 America Ct Davidsonville 21035									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/13/84		23c. NAME OF CEMETERY OR CREMATORY Lake View Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Maryland					
24. FUNERAL DIRECTOR NAME Mc Cully Funeral Home of Pasadena Mountain and Tick Neck Roads Pasadena, Md. 21122						25. DATE REC'D BY REGISTRAR (25) REGISTRAR'S SIGNATURE APR 12 1984 John Davidson					

BP

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DHMH - 16 50M 4/83
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										09083			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST ELIZABETH NMM COOK			2a. DATE OF DEATH			MONTH DAY YEAR 4-1-84		2b. HOUR 255 PM		
3. SEX FEMALE			4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR MAY 12 1919			6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. CAROLINA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH A.A.			MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. GENERAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) COOK			12b. KIND OF BUSINESS OR INDUSTRY RESTAURANT				
13a. STATE MD.			13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1130 Eastport Terrace 21403				
14. FATHER'S NAME FIRST MIDDLE LAST Willie Hayes			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Finch			ADDRESS ANNAPOLIS							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 312-306182			17. INFORMANT George Cook - 1130 Eastport Terrace							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease. DUE TO, OR AS A CONSEQUENCE OF (c) ASCOT										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4-4-84 to 3-31-84, that (I) (we) last saw the deceased alive on 3/31/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.													
22b. SIGNATURE E. A. Hull			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/2/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. A. Hull			22e. ADDRESS 1001-1001 1st Ave, Annapolis										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-5-1984			23c. NAME OF CEMETERY OR CREMATORY Brewer Hill			23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS A.A. MD				
24. FUNERAL DIRECTOR NAME C.E. Hicks			ADDRESS 1922 Forest Drive			25a. DATE REC'D. BY REGISTRAR APR 4 1984			REGISTRAR'S SIGNATURE John Davidson				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09084

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Evelyn Estella COOPER			2a. DATE OF DEATH MONTH DAY YEAR April 8, 1984			2b. HOUR M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 24, 1912		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.			
10. CITY OR TOWN OF DEATH Pasadena		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 185 Riviera Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse Aid		12b. KIND OF BUSINESS OR INDUSTRY Conv. Home	
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Pasadena		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 185 Riviera Drive 21122	
14. FATHER'S NAME FIRST MIDDLE LAST William G. Loney				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Fishbach					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Son William A. Watts		ADDRESS Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic CARCINOMA to Lung Liver</u> 1539 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Colon Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> 19 <u>83</u> , to <u>4/07</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>4/06</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Michael E. Garahy</u>			DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <u>5/08/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL E. GARAHY, M.D.			22e. ADDRESS MICHAEL SMALLWOOD RD.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr. 11, 84		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore AND 2112 MD		
24. FUNERAL DIRECTOR NAME A. B. V. V. V.			ADDRESS Singleton Funeral Home, Glen Burnie, Md		25a. DATED BY REGISTRAR APR 10 1984				

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

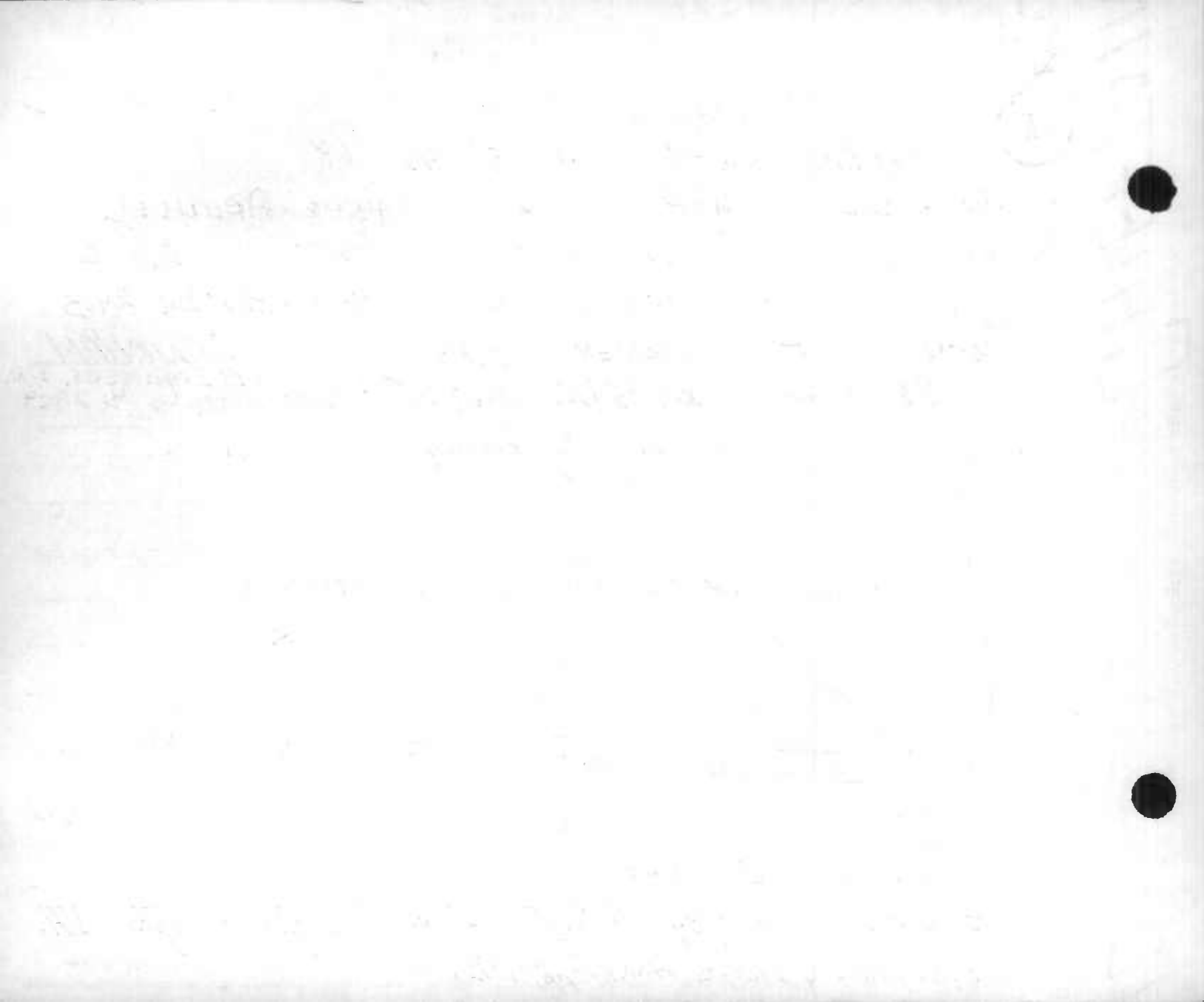
09085

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EDNA Virginia COTHRAN			2a. DATE OF DEATH MONTH DAY YEAR 4-5-84			2b. HOUR 9:15 AM		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 4 5 1916		
6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH D.C.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		
9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.			10. USUAL OCCUPATION (TYPE OF WORK, OR MOST OF WORKING LIFE) SECT.			11. KIND OF BUSINESS OR INDUSTRY OFFICE		
12. CITY OR TOWN OF DEATH ANNAPOLIS			13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF DEATH IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. Gen. Hosp.			14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. 13b. COUNTY A.A. 13c. CITY OR TOWN ANNAPOLIS		
15. FATHER'S NAME FIRST MIDDLE LAST JOHN A COONEY			16. MOTHER'S MAIDEN NAME MIDDLE LAST MARY LANHAM			17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			19. SOCIAL SECURITY NO. 224 484 222			20. INFORMANT ROBERT S. COTHRAN ADDRESS 298 EDEMERE DR. ANNAPOLIS MD. 21403		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY 1629 IMMEDIATE CAUSE (a) Ca of lung. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Chronic obstructive lung disease								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 6 19 83, to 4/5 19 84, that (I) (we) lost saw the deceased alive on 3/31 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.								
22b. SIGNATURE Rodney L. Brimhall MD						22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 4/5/84
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Rodney L. Brimhall						22f. ADDRESS		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 4/9/84			23c. NAME OF CEMETERY OR CREMATORY Arlington National		
23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Arlington VA.			24. FUNERAL DIRECTOR NAME ADDRESS Taylor Funeral Chapel ANNAPOLIS, MD.			25a. DATE REC'D. BY REGISTRAR APR 11 1984		
25b. REGISTRAR'S SIGNATURE C. Davidson-Randall								

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										09086		EST	
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST JAMES		MIDDLE H		LAST COULTAS		JR		2a. DATE OF DEATH MONTH DAY YEAR APRIL 6, 1984		2b. HOUR 130 AM	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Jan. 24, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.							
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance		12b. KIND OF BUSINESS OR INDUSTRY Gless Works					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY A. A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 414 "J" Hidden Brook Dr. 21061					
14. FATHER'S NAME FIRST MIDDLE LAST Janes Herbert Coultas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Violet Sadie Lovett											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-14-9673		17. INFORMANT ADDRESS Helen C. Clultas Same as above									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Fibrosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hodgkins Disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>6 months</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>1980</u> , 19 <u>83</u> , to <u>April 1984</u> , that (I) (we) lost saw the deceased alive on <u>4/14</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not view the body after death.)													
22b. SIGNATURE <u>Philip Konits</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED <u>4/17/84</u>			
22b. PHYSICIAN'S NAME (TYPE OR PRINT) PHILIP H. KONITS, M.D.		22c. ADDRESS 615 HAMMONDS LANE BALTIMORE, MARYLAND 21225											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/9/1984		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Baltimore, Md.							
24. FUNERAL DIRECTOR NAME Raymond C. Fink		ADDRESS Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR APR 9 1984		25b. REGISTRAR'S SIGNATURE <u>John H. ...</u>							



APR 8 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09087

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bessie L. COZART			2a. DATE OF DEATH MONTH 4 DAY 16 YEAR 84			2b. HOUR 5:39 M.					
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH 2 DAY 26 YEAR 90		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.					
10. CITY OR TOWN OF DEATH Edgewater		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant Living Conv. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) School teacher		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. CITY OR TOWN Anne Arundel		13c. CITY OR TOWN Annapolis		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 900 Nicholson St. 21401		
14. FATHER'S NAME FIRST William MIDDLE LAST Barbare			15. MOTHER'S MAIDEN NAME FIRST IDA. MIDDLE LAST Scott			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				17. INFORMANT ADDRESS Annapolis, Md. 21401	
18a. SOCIAL SECURITY NO. 235-82-1618			17. INFORMANT RUBY SIMMS			17. INFORMANT 900 Nicholson St.			17. INFORMANT 900 Nicholson St.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4280 Congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Anemia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE William Reese DEGREE						22c. DATE SIGNED 4/16/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4-19-84		23c. NAME OF CEMETERY OR CREMATORY GREENWOOD MEM. PARK			23d. LOCATION CITY OR TOWN Beckley COUNTY W. Virginia STATE			
24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A.						25a. DATE REC'D. BY REGISTRAR APR 19 1984 REGISTRAR'S SIGNATURE Julia Davidson-Randall					

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09088

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Joseph L. Creek</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4 10 84</i>			2b. HOUR <i>7¹⁰ A</i> M			
3. SEX <i>male</i>		4. RACE <i>Black</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>9 18 90</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>93</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Anne Arundel Co.</i> MD.			
10. CITY OR TOWN OF DEATH <i>Glen Burnie md</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>MD. Manor Nsg Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>21032</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>A.A.</i>		13c. CITY OR TOWN <i>EDGEWATER</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>JOSEPH CREEK, Sr.</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>DIANE PARKER</i>				16. ADDRESS <i>Edgewater, Md. 21037</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>		16b. SOCIAL SECURITY NO.		17. INFORMANT <i>RICHARD CREEK</i> ADDRESS <i>3575 Solomons Island Rd.</i>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *CARDIAC Arrest*

4449
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *ARTERIAL occlusive disease*

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Dr. P. R. Herenstein</i>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. P. R. Herenstein</i>				22e. ADDRESS <i>7575 E Howard Rd Glen Burnie md</i>			

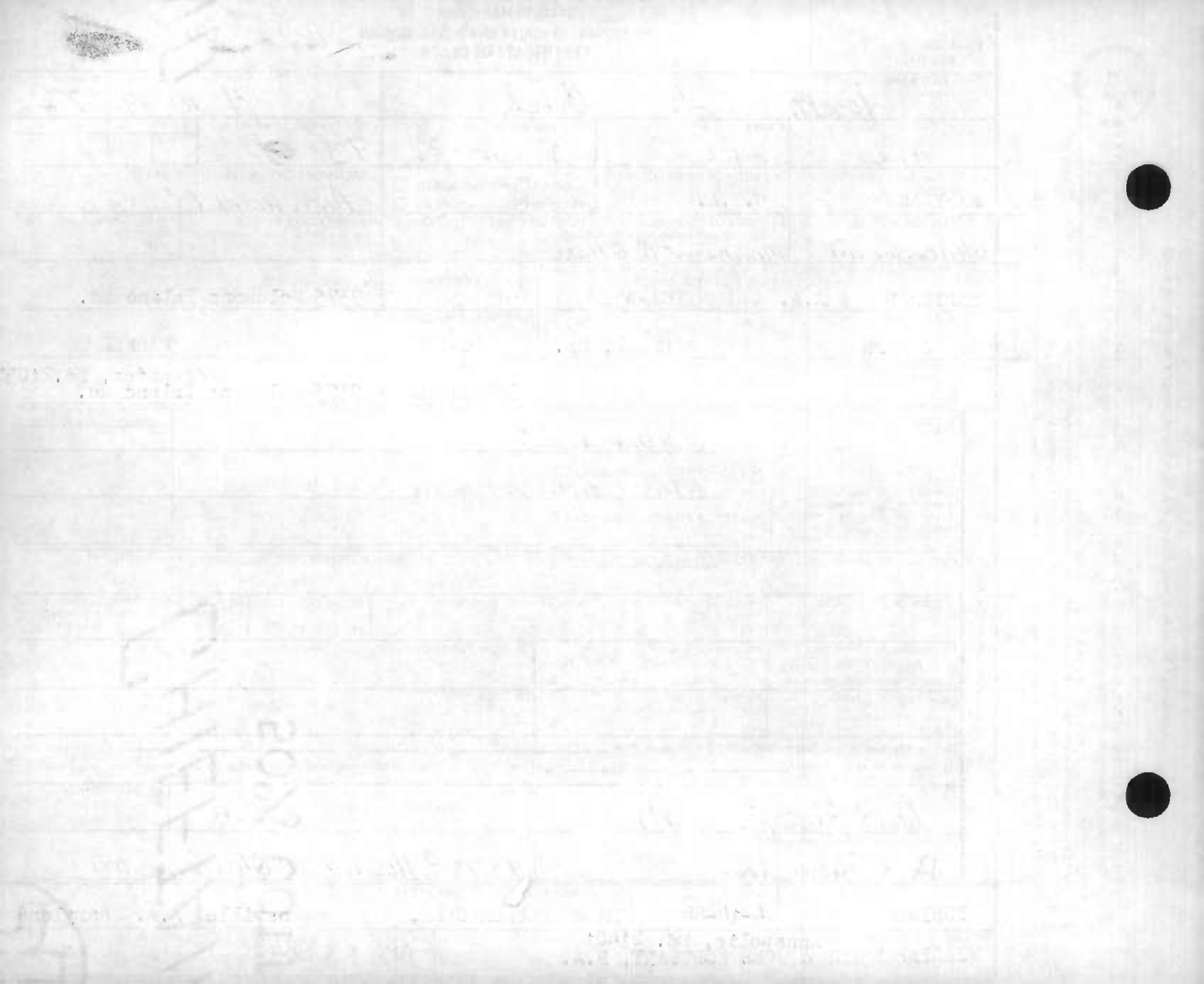
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>4-14-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>CHEWS CHURCH CEME.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Owensville A.A. Maryland</i>	
24. FUNERAL DIRECTOR <i>Annapolis, Md. 21401</i> <i>WILLIAM REESE & SONS MORTUARY, P.A.</i>				25a. DATE REC'D. BY REGISTRAR <i>APR 13 1984</i>		25b. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				09089			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Claude Cromwell				2a. DATE OF DEATH MONTH DAY YEAR 4 17 84		2b. HOUR M AM	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 2 25 06		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS	
14. FATHER'S NAME FIRST MIDDLE LAST ALBERT CROMWELL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES PORTER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-18-0944		17. INFORMANT ADDRESS Marie Cromwell 1410 Log Inn Rd. Annapolis, Md. 21401			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Asphyx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/1/84 19 84 , to April 19 84 , that (I) (we) last saw the deceased alive on 4/1/84 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/1/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-21-1984		23c. NAME OF CEMETERY OR CREMATORY ASBURY BROADNECK CEME		23d. LOCATION CITY OR TOWN COUNTY STATE St. Margarets A.A. Maryland	
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.				25a. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE APR 19 1984			

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09090

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LULA. M. CRONEY			2a. DATE OF DEATH MONTH DAY YEAR 4 11 84			2b. HOUR 9 ²⁵ A.M.	
3. SEX F	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 1 4 77	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) KENTUCKY	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.				
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND		13b. COUNTY A.A.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2001 Allis Street 21401	

14. FATHER'S NAME FIRST MIDDLE LAST SAMUEL GORDON		15. MOTHER'S MAIDEN NAME MIDDLE LAST SOPHIA GARRETT	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)	
17. INFORMANT FANNIE M BROWN		ADDRESS Annapolis, Md. 21401 2001 Allis St.	

18. CAUSE OF DEATH (Enter only one cause per line for a, b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 2500 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertension</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).		

MEDICAL CERTIFICATION

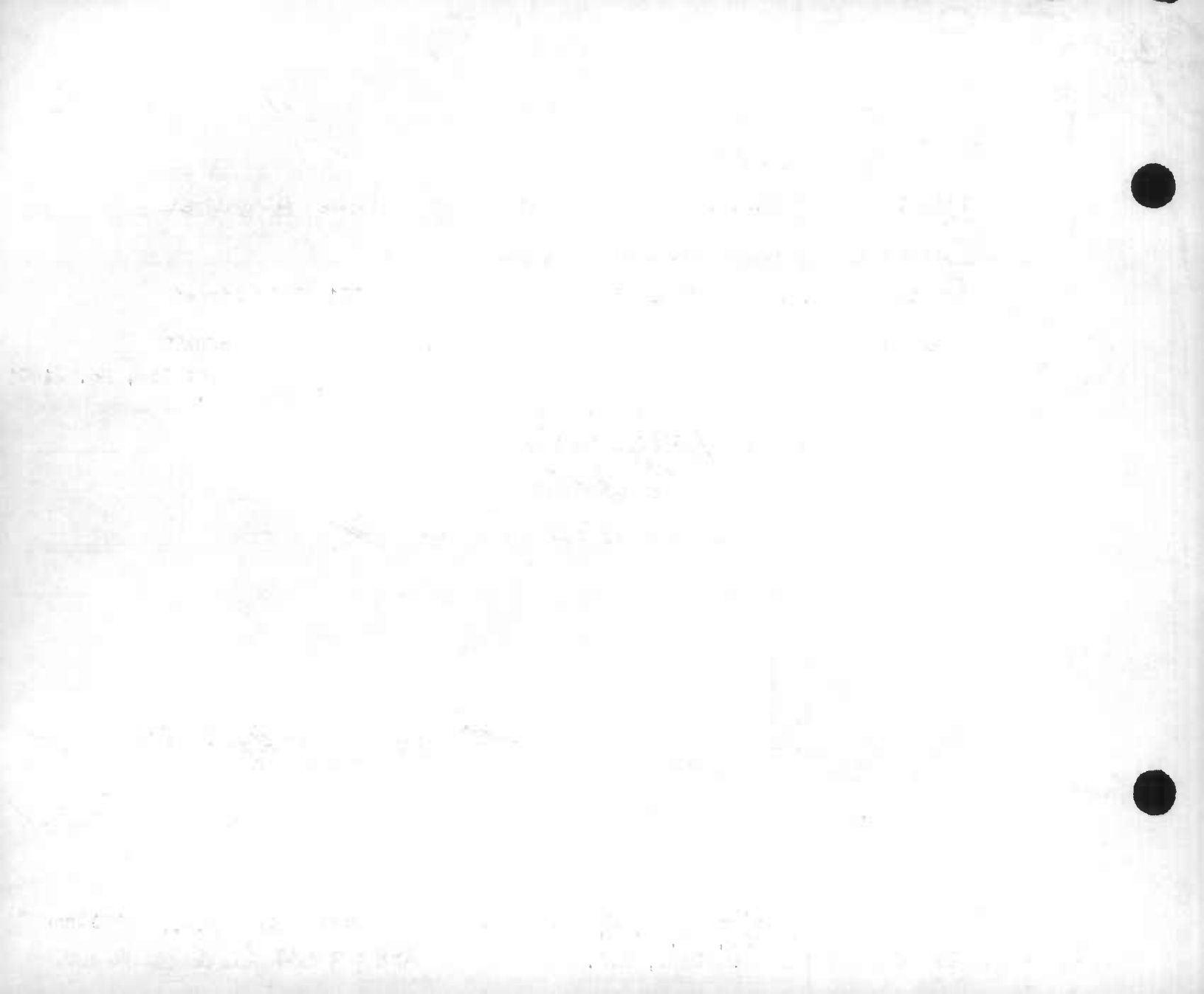
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION CITY OR TOWN COUNTY STATE Feb 11 April 19 84	
22a. I certify that (I) (the hospital) attended the deceased from saw the deceased alive on 11 April 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated (above) (I) (we) did (did not) view the body after death.			
22b. SIGNATURE J. J. Reese		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 11 April 84
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 4-14-84	23c. NAME OF CEMETERY OR CREMATORY PINELAWN MEM. PARK	23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. Maryland
24. FUNERAL DIRECTOR WILLIAM REESE & SONS MORTUARY, P.A.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 13 1984 Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked either "a" or "b", it shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 9 0 9 1			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Christina A. Crowner										DATE ESTIMATED XX 4-12-84		M	
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 12 2 83		6. AGE (IN YEARS) (LAST BIRTHDAY) YRS. 4		IF UNDER 1 YR. MONTHS DAYS		7c. DATE PRONOUNCED DEAD		7d. HOUR 12:05 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD.	
10. CITY OR TOWN OF DEATH Annapolis				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MARYLAND				13b. COUNTY A.A.		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 114 Victor Parkway 21403			
14. FATHER'S NAME FIRST MIDDLE LAST CALVIN CROWNER						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CYNTHIA JOHNSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS CYNTHIA CROWNER 114 Victor Parkway 21403				Annapolis, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 7980 IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE Dennis F. Smyth, M.D.				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 4-13-84	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL BURIAL				23b. DATE 4-16-84		23c. NAME OF CEMETERY OR CREMATORY ASBURY BROADNECK CEME.				23d. LOCATION CITY OR TOWN COUNTY STATE St. Margarets A.A. Maryland			
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.						25a. DATE REC'D. BY REGISTRAR APR 19 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson					

1/2



DATE	DESCRIPTION	AMOUNT	CHECK NO.	REMARKS
1/1/50
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09092

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) George S. Dattore Sr.			2a. DATE OF DEATH MONTH DAY YEAR 4 24 84			2b. HOUR 1245 P.M.				
1. SEX MALE		1. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 5/28/14		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.				
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Insurance Agent		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Anne Arundel		13c. CITY OR TOWN West River		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Dattore					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia Moreconi					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII		17. INFORMANT ADDRESS Dolores C. Dattore same as item 13					

18. CAUSE OF DEATH (Enter only one cause per line form (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary edema

DUE TO, OR AS A CONSEQUENCE OF

(b) **Metastasis Mediastinum, esophagus**

DUE TO, OR AS A CONSEQUENCE OF

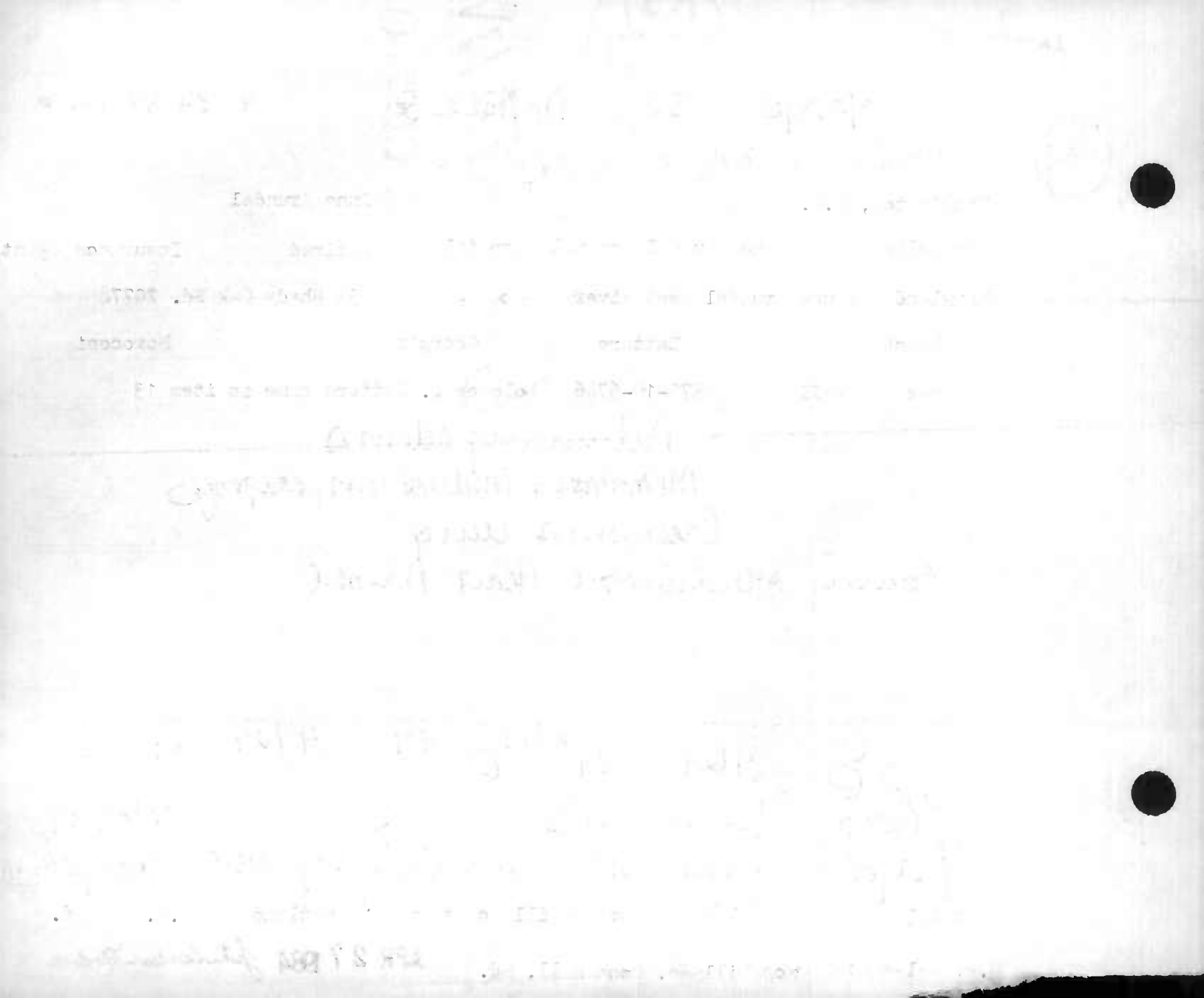
(c) **Carcinoma Lung**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Cornary Atherosclerotic Heart Disease

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I, this hospital) attended the deceased from above (I/we) did not view the body after death.							
22b. SIGNATURE George C. Samaras		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/24/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) George C. Samaras		22e. ADDRESS 205 Ridgely Ave. Annapolis Md.					

23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 4/27/84		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS G.P. Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.				25a. DATE REC'D. BY REGISTRAR APR 27 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	



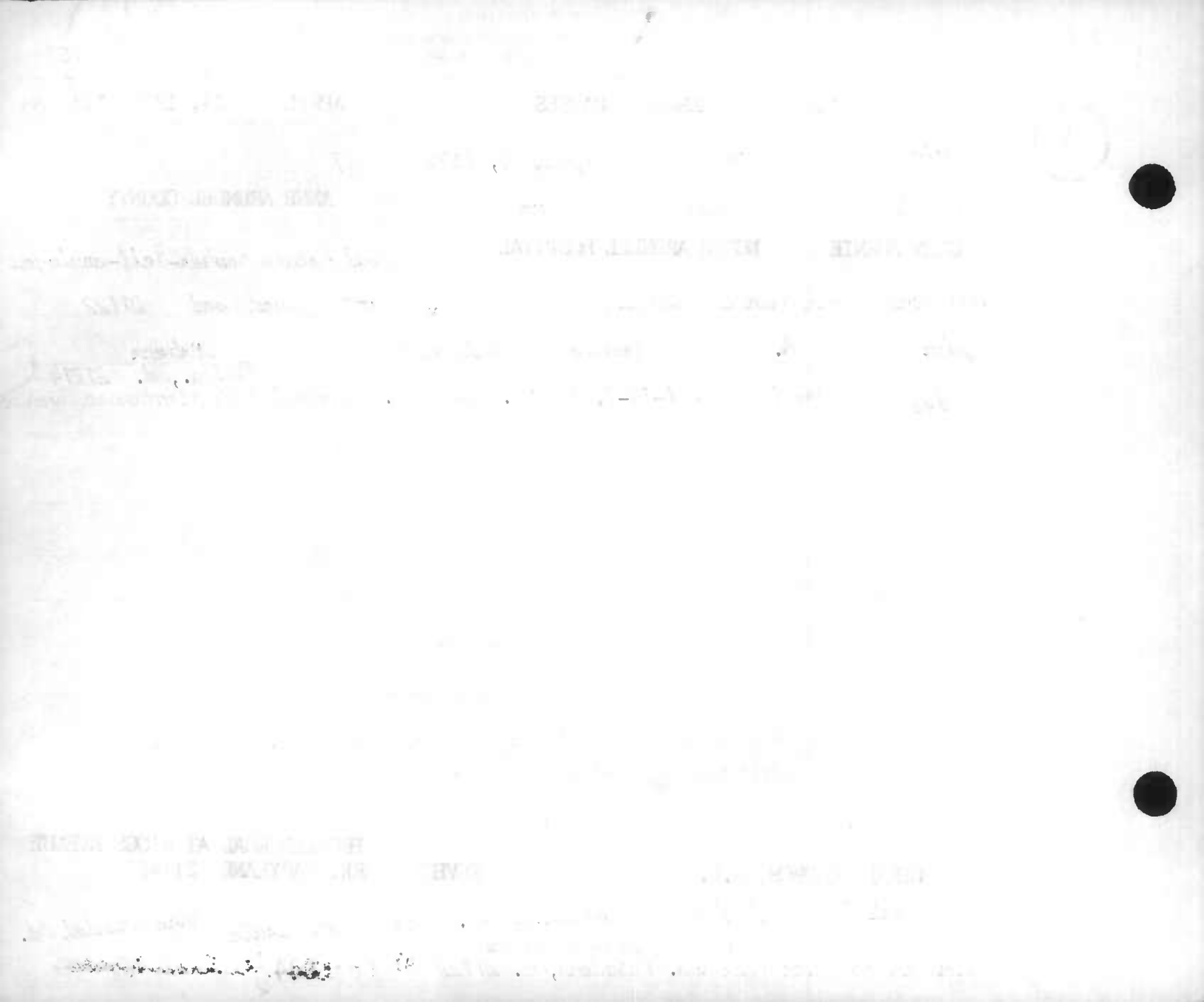
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 09093		EST	
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) JOHN CASPER DAUSES				2a. DATE OF DEATH MONTH APRIL DAY 25 YEAR 1984				2b. HOUR 1210 AM M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH July DAY 15 YEAR 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS HOURS MIN. 			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.							
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, FACTORY, OR OTHER INSTITUTION) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Real Estate Broker-Self-employed		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE 1. IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Pasadena				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1566 Elford Road 21122							
14. FATHER'S NAME FIRST John MIDDLE A. LAST Dauses				15. MOTHER'S MAIDEN NAME FIRST Kunigunda MIDDLE Dinbeck LAST 				ADDRESS Balto., Md. 21214					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 001-14-9788		17. INFORMANT Mr. George J. Campbell				ADDRESS 2707 Strathmore Avenue					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 4340 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral thromboses DUE TO, OR AS A CONSEQUENCE OF (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 2 weeks			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Ischemic heart disease, cardiac arrest, congestive heart failure													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 3/31 , 19 84 , to 4/25 , 19 84 , that (I) (we) lost saw the deceased alive on 4/24 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE Gerard Church				DEGREE				22c. DATE SIGNED 4/25/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) GERARD CHURCH, M.D.				22e. ADDRESS 8 EVERGREEN ROAD AT RIGGS AVENUE SEVERNA PARK, MARYLAND 21146									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/28/84		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park		23d. LOCATION CITY OR TOWN Glen Burnie COUNTY Anne Arundel STATE Md.							
24. FUNERAL DIRECTOR NAME Mc Cully Funeral Home of Pasadena ADDRESS Mountain and Tick Neck Rds. Pasadena, Md. 21122						25a. DATE REC'D. BY REGISTRAR 1-1-84 25b. REGISTRAR'S SIGNATURE Wardson Riddell							



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										09094		EST	
1. FOR STATE REGISTRAR				REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) BENJAMIN PETER DAVIS				2a. DATE OF DEATH MONTH DAY YEAR APRIL 13, 1984				2b. HOUR 0412 PM					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 8, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.							
10. PLACE OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor		12b. KIND OF BUSINESS OR INDUSTRY Const.					
13a. STATE Maryland				13b. COUNTY A. A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 310 Ferndale Road 21061			
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Howard Davis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl = White									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No.		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-09-3188		17. INFORMANT Hazel L. Davis				ADDRESS same as above 21061					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Severe Chronic Obstructive Lung Disease years DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Sudden													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4-13-84, to 4-13-84, that (I) (we) lost saw the deceased alive on 4-13-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death													
22b. SIGNATURE JACK STERN MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4-13-84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JACK STERN MD				22e. ADDRESS 300 HOSPITAL DRIVE GLEN BURNIE MARYLAND 21061									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/16/84		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard, Md.					
24. FUNERAL DIRECTOR NAME Raymond C. Fink				ADDRESS Glen Burnie, Md.		25a. DATE REC'D. BY REGISTRAR APR 16 1984		25b. REGISTRAR'S SIGNATURE Sheila Davidson-Randall					



THE STATE OF NEW YORK
IN SENATE
JANUARY 1, 1901.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the deceased. The State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09095

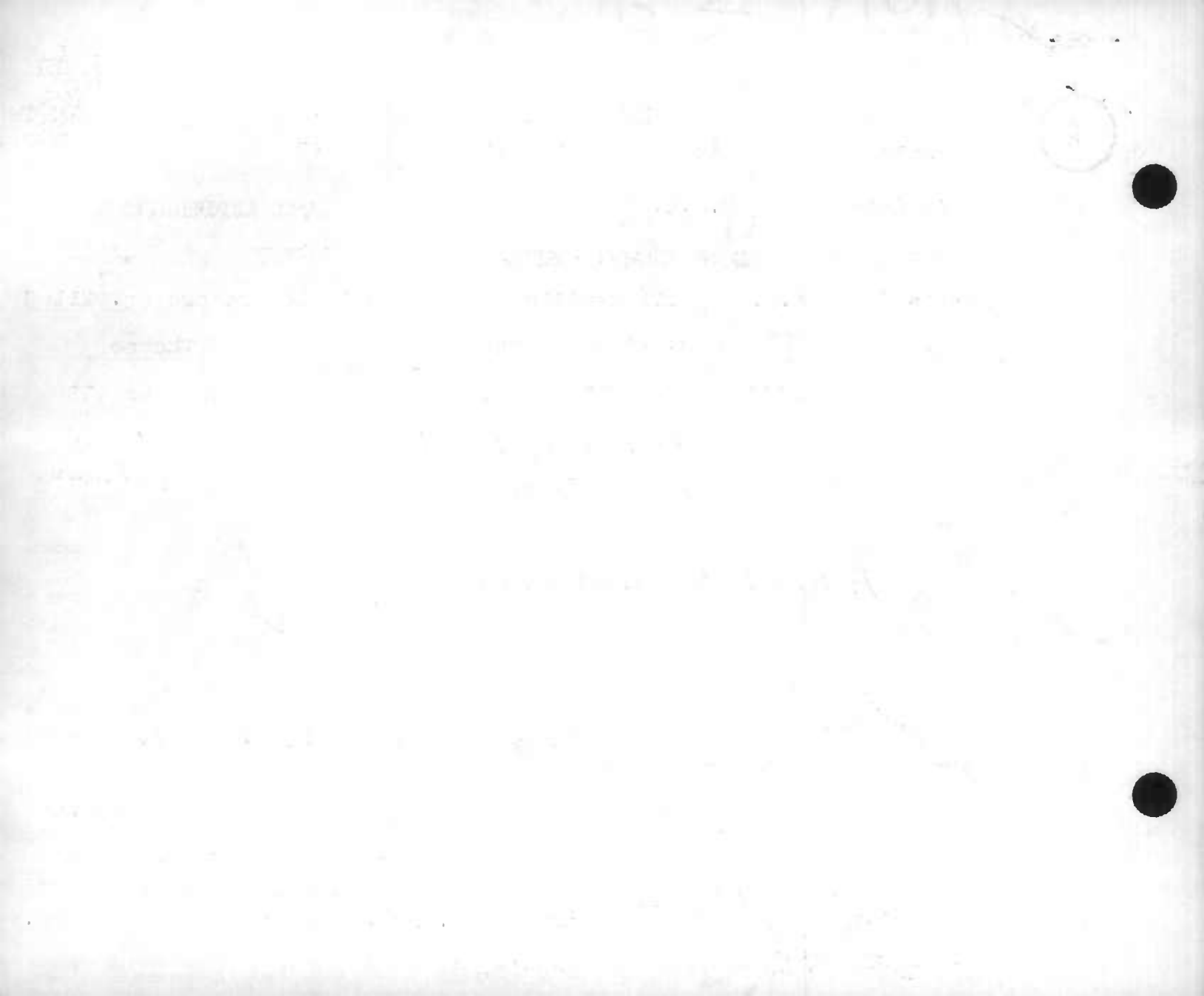
1 - FOR
STATE
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA WIGGINS DAVIS			2a. DATE OF DEATH MONTH DAY YEAR APRIL 14, 1984		2b. HOUR 0515 PM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 6, 1896	6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.		
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Office
13a. STATE Maryland		13b. COUNTY A.A.	13c. CITY OR TOWN Millersville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ASA Wiggins		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Thomas			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 111111	17. INFORMANT (Daughter) ADDRESS 226/05/3198 Mrs. Jean Mendelsohn Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 5860 DUE TO, OR AS A CONSEQUENCE OF (b) Renal Failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min unknown
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Arteriosclerotic Heart Disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 3-28 19 84 to 4-14 19 84 , that (I) (we) lost saw the deceased alive on 4-14 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE 		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-14-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG, S. J. M.D.		22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. NAME OF CEMETERY OR CREMATORY Penninsula Mem. Prk.		23c. LOCATION CITY OR TOWN COUNTY STATE Newport News Va.	
24. FUNERAL DIRECTOR NAME Singleton Funeral Home Glen Burnie, Md		25a. DATE REC'D. BY REGISTRAR APR 17 1984		25b. REGISTRAR'S SIGNATURE 	

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked ex, here, it shows any injury, or other traumatic event, the medical examiner must be notified by one of the following: 1. The attending physician, 2. The funeral director, 3. The coroner, or 4. The medical examiner.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

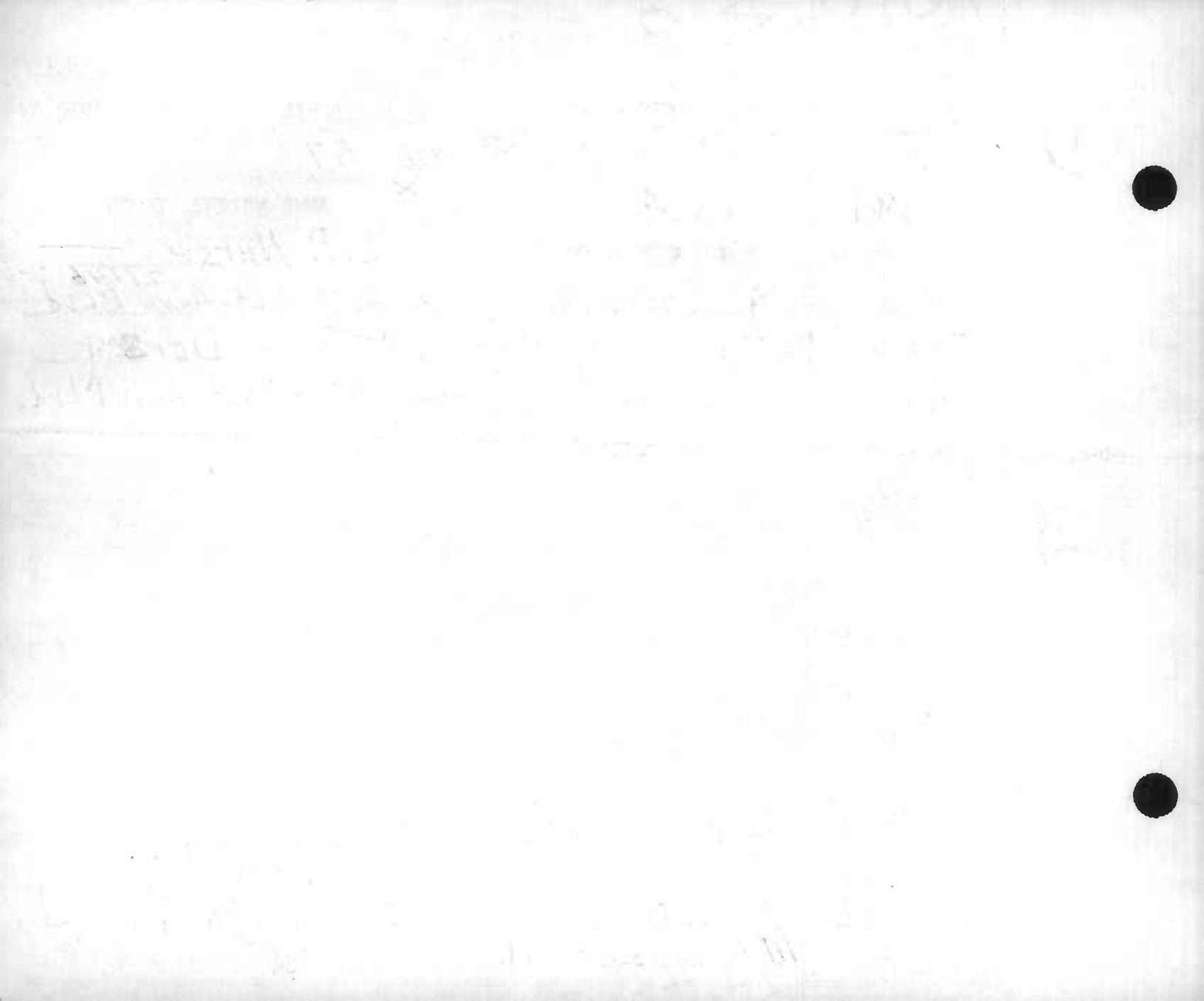
09096

REG. NO.

E T

1. DECEASED NAME (TYPE OR PRINT) FLORENCE VIRGINIA DAY			2a. DATE OF DEATH MONTH DAY YEAR APRIL 06 1984			2b. HOUR 1030 AM					
3. SEX F.		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR Dec. 3-1926		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (1) IF OF WORK OR MOST OF WORKING LIFE L.P. Nurse		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md		13b. COUNTY A.A. Severna Pk.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13. STREET ADDRESS / ZIP CODE 957-BALT-ANNA BLVD 21146					
14. FATHER'S NAME FIRST MIDDLE LAST James Nathaniel Day				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Geneva Dorsey							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 516-22-3079		17. INFORMANT ADDRESS Mother-957-BALT-ANNA BLVD.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>None</u>											
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.											
22b. SIGNATURE <i>Paul Rosoff</i>				DEGREE MD				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. PAUL ROSSOFF				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> ADDRESS 425 RITCHIE HIGHWAY S.E. GLEN BURNIE, MD. 21061							
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Apr. 11-84		23c. NAME OF CEMETERY OR CREMATORY Carpenters Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Severna Pk. A.A. Md					
24. FUNERAL DIRECTOR C.E. Hicks III Annapolis Md.				25a. DATE REC'D. BY REGISTRAR APR 9 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Hendall					

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the Registrar within 24 hours after death.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

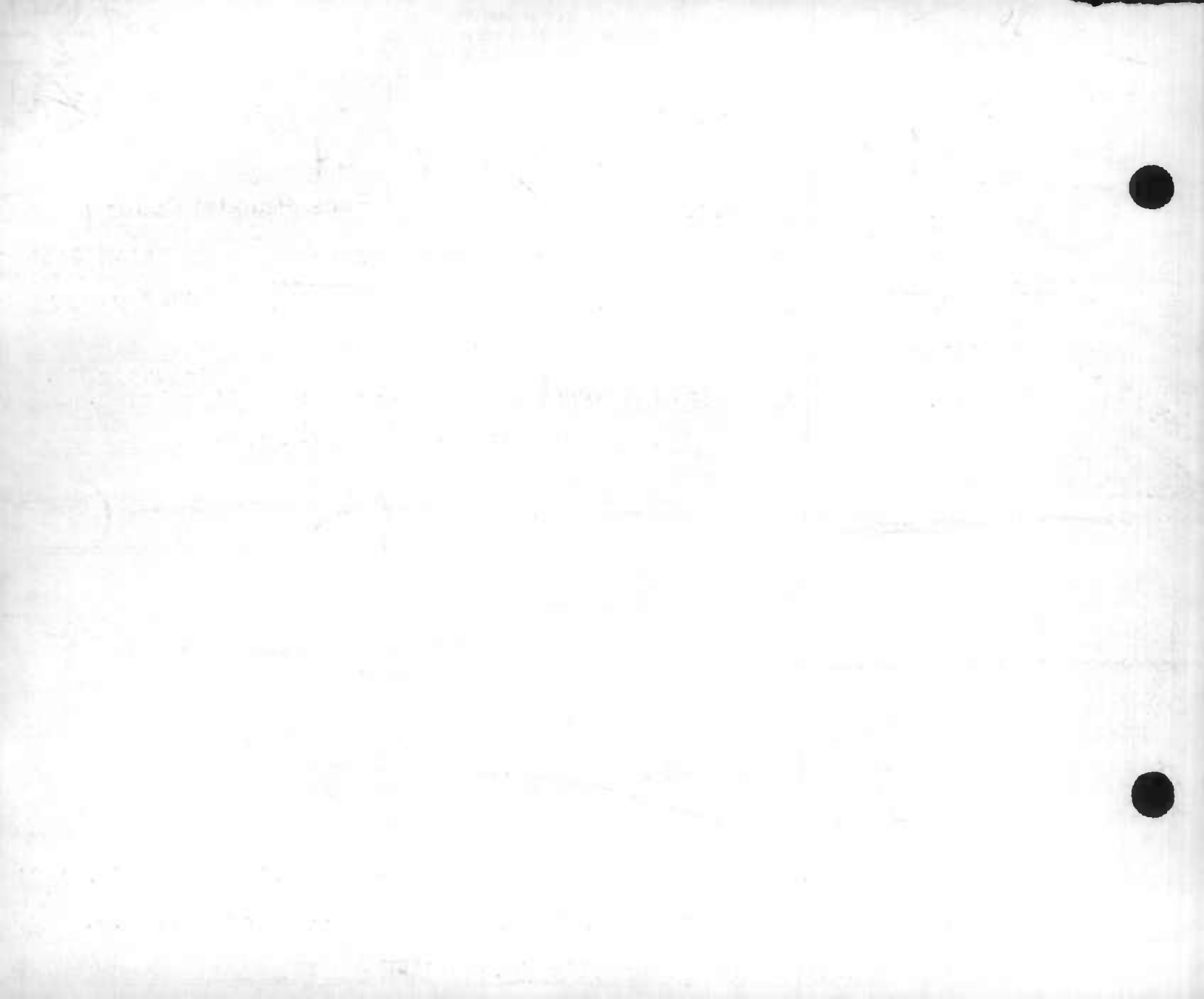
09097

FOR
1 - STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Charles, David Dempsey			2a. DATE OF DEATH MONTH DAY YEAR 4 / 5 / 84			2b. HOUR 356 PM			
3. SEX M		4 RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 5 10 19		6 AGE (IN YEARS, LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Railroad		12b. KIND OF BUSINESS OR INDUSTRY Union Station	
13a. STATE MD		13b. COUNTY A.A.		13c. CITY OR TOWN Edgewater		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1550 Ridgely Ave 21037	
14 FATHER'S NAME FIRST MIDDLE LAST Silas Howard Dempsey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eunice Hughes Dempsey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes. WWII				16b. SOCIAL SECURITY NO. 577-18-4899		17. INFORMANT ADDRESS Thelma Dempsey 1550 Ridgely Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE H. D. Goldstein					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard D. Goldstein					22e. ADDRESS 205 Ridgely Ave. Annapolis Md. 21401				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/9/84		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Md. P.G.		
24. FUNERAL DIRECTOR NAME Hardesty Funeral Home Annapolis Md. 21401					25a. DATE REC'D. BY REGISTRAR APR 6 1984				
25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

BP _____



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09093

FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST STUART PARKER DILLON			2a. DATE OF DEATH MONTH DAY YEAR 4-10-84		2b. HOUR 3:17 PM
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 11-29-99		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (GIVE WORK FOR MOST OF WORKING LIFE) Ret Lt. Col.		12b. KIND OF BUSINESS OR INDUSTRY U.S. ARMY
13a. STATE MD	13b. COUNTY AA Co	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 1010 Mastline Dr. 21401	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES DILLON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GRACE DIVELEY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 234630446		17. INFORMANT ADDRESS Virginia C. Dillon #13	

1. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

0381

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (I) (this hospital) attended the deceased from **4-3-84** to **4-10-84**, that (I) (we) lost saw the deceased alive on **4-10-84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE John Rowe	DEGREE	22c. DATE SIGNED 10 April 84
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS 77 West St. Annapolis MD.	
22f. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
23a. BURIAL, CREMATION, REMOVAL (CHECK) BURIAL	23b. DATE 4/14/84	23c. NAME OF CEMETERY OR CREMATORY Beverly Hills Memory Garden
23d. LOCATION CITY OR TOWN COUNTY Annapolis MD.	23e. DATE REC'D. BY REGISTRAR APR 11 1984	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel	24b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified as required by law.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		WILSON M. DUGGAN		09099		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) DUGGAN M WILSON				2a. DATE OF DEATH April 28, 1984		2b. HOUR 10:45 AM			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 10 21 05		6. AGE (IN YEARS LAST BIRTHDAY) 78		7. IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IRELAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.			
10. CITY OR TOWN OF DEATH ANNAPOLIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ANNE ARUNDEL GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ACCOUNTANT		12b. KIND OF BUSINESS OR INDUSTRY TAXI CAB			
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL		13c. CITY OR TOWN SEVERNA PARK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 441 BENDALE RD. 21146	
14. FATHER'S NAME HAMILTON				15. MOTHER'S MAIDEN NAME (UNKNOWN)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 127-12-6619		17. INFORMANT AGNES M. KLEMENS		ADDRESS (SAME AS ABOVE (13))			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral infarction</u> 4349 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from <u>5-26-77</u> to <u>4-28</u> 19 <u>84</u> , that (we) last saw the deceased alive on <u>4-28</u> 19 <u>84</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles W. Kinser				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-28-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES W. KINSER MD				22e. ADDRESS 16 MURRAY AV. ANNAPOLIS, MD.					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE 4-30-84		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE WESTVIEW BALTIMORE MD.			
24. FUNERAL DIRECTOR NAME ROBERT S. BARRANCO				25. DATE MAY 4 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

BP

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Handwritten notes on lined paper, including a date stamp "MAY 4 1964" and various illegible text fragments.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 11b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALBERT MYRON DUNNINGTON		7a. DATE OF DEATH KNOWN OF ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 19 4-6-84		7b. HOUR M AM
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 4 2 1928	6. AGE (IN YEARS) LAST BIRTHDAY 56 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mission Support
13a. STATE Maryland		13b. COUNTY Q.A.		13c. CITY OR TOWN Stevensville
14. FATHER'S NAME FIRST MIDDLE LAST John Wesley Dunnington		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ada (unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 220-14-0807		17. INFORMANT ADDRESS Noveleen H. Dunnington, Stevensville, MD
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Carcinoma of lung + brain mets				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE James E. Wheeler		TITLE (SPECIFY) Deputy		DATE SIGNED 4-6-84
EXAMINER'S NAME (TYPE OR PRINT) James E. Wheeler		ADDRESS 910 Primrose Rd Annap.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 04/09/84	23c. NAME OF CEMETERY OR CREMATORY National Mem. Park	
24. FUNERAL DIRECTOR NAME Tom Helfenbein		ADDRESS Fairfax, Virginia		25b. DATE REC'D. BY REGISTRAR APR 11 1984
		25c. REGISTRAR'S SIGNATURE Davidson-Rendell		



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09101

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Maurice Edward DURSCHLAG			2a. DATE OF DEATH MONTH DAY YEAR April 22, 1984			2b. HOUR 8:20 ^A			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb 11, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) * 1828 Norfolk Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Coal Miner		12b. KIND OF BUSINESS OR INDUSTRY Mines	
13a. STATE Maryland		13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 1828 Norfolk Road 21061	
14. FATHER'S NAME FIRST MIDDLE LAST Richard O. Durschlag				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Agnes Merch-Myer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Son		ADDRESS Glen Burnie Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Supras. Multiple large infarct 7070 DUE TO, OR AS A CONSEQUENCE OF (b) Decubitus ulcers DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21i. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE H. Towhidian, MD DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/23/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAMID TOWHIDIAN						22e. ADDRESS 3236 MOUNTAIN RD, PASADENA MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Apr 25, 84		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem pk		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD		21122
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, MD ADDRESS _____						25a. DATE REC'D. BY REGISTRAR APR 24 1984		25b. REGISTRAR'S SIGNATURE John Davidson	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Registrar to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 above, any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____



Handwritten notes and stamps at the top of the page, including a date stamp "JAN 11 1961" and various illegible markings.

Handwritten text, possibly a signature or title, written in cursive.

Main body of handwritten notes and stamps, including a large "V" mark and various illegible markings.

FOR Add Info. Film G590 4/25/84 *cam* STATE OF MARYLAND
 1 - STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 REGISTRAR CERTIFICATE OF DEATH 09102

REG. NO.

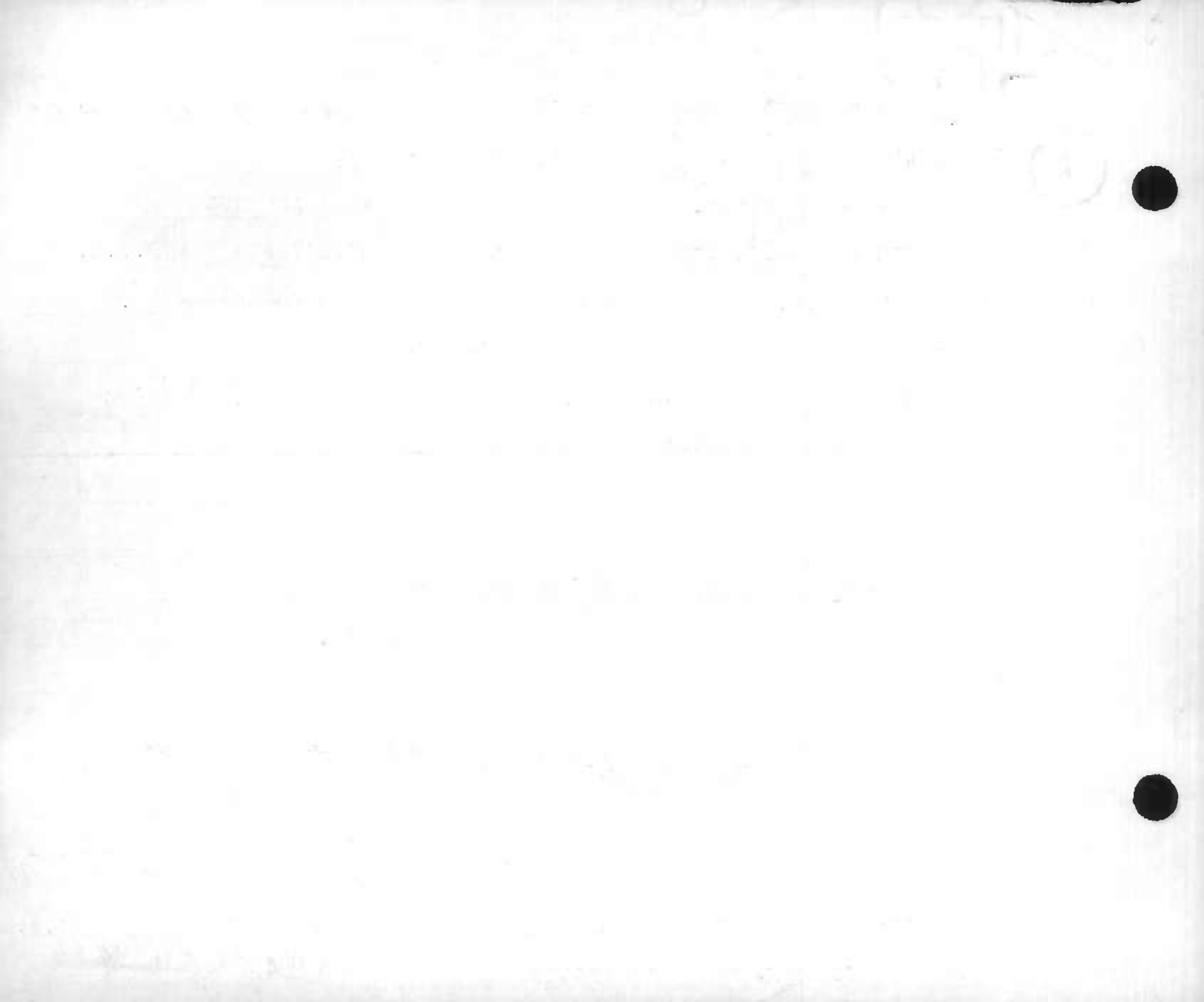
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WINNIFRED BERDINE DYER			2a. DATE OF DEATH MONTH DAY YEAR APRIL 7 1984		2b. HOUR 4:40 PM
3. SEX FEMALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR AUG. 17 1911		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. St. Aberdeen	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ANNAPOLIS	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) A.A. GENERAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SUPERVISOR		12b. KIND OF BUSINESS OR INDUSTRY F.T.C.
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY A.A.	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST DENNIS FRANKLIN Berdine			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LOUISE Winnifred E. Powell		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-44-2484		17. INFORMANT ADDRESS BOBBIE CARTER 930 ALCONA ST. LANHAM, MD 20706	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>carcinoma of pancreas</i> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Hepatic metastases, anemia</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (he/she) (this hospital) attended the deceased from <i>Dec</i> 19 <i>83</i> , to <i>4-7</i> 19 <i>84</i> , that (he/she) lost saw the deceased alive on <i>4-6</i> 19 <i>84</i> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did/did not) view the body after death.					
22b. SIGNATURE <i>G. Mitchell</i>		DEGREE		22c. DATE SIGNED 4-9-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>G. Mitchell, MD</i>		22e. ADDRESS <i>205 Ridge Dr. Annapolis, MD</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 4/10/84		23c. NAME OF CEMETERY OR CREMATORY WESTVIEW CREMATORY	
23d. LOCATION CITY OR TOWN BALTIMORE		COUNTY MD.		STATE	
24. FUNERAL DIRECTOR NAME HARDESTY FUNERAL HOME		ADDRESS ANNAPOLIS, MD		25a. DATE REC'D. BY REGISTRAR APR 10 1984	
25b. REGISTRAR'S SIGNATURE <i>Lila Davidson-Randell</i>					

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09103

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Blair E. Eckard			2a. DATE OF DEATH MONTH DAY YEAR April 25, 1984			2b. HOUR 1:37 P			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 17 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.			
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinest		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.	
13a. STATE Md.		13b. COUNTY Anne Arundel		13c. CITY OR TOWN Crownsville		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS / ZIP CODE 1151 Blue Bird Lane 21032	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Eckard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Suzanne Biddle					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 209-10-2907		17. INFORMANT ADDRESS Grace L. Eckard, Wife, Same as Above					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immed. yes									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Left Bundle Branch Block; Adenocarcinoma prostate.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 25 apr 1984 to 25 Apr 84 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE William H. Choate				DEGREE MD. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 26 apr 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William H. Choate, M.D.				22e. ADDRESS Annapolis, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-30-84		23c. NAME OF CEMETERY OR CREMATORY GreenLawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Holidaysburg, Blair, Pa.			
24. FUNERAL DIRECTOR NAME Robt E Wilhelm				ADDRESS 4308 Suitland Rd., Suitland, Md.		25a. DATE REC'D. BY REGISTRAR MAY 1 1984		25b. REGISTRAR'S SIGNATURE John E. ...	

BP

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2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09104

EST

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM M ELDRIDGE SR				2a. DATE OF DEATH MONTH DAY YEAR APRIL 16, 1984				2b. HOUR 4:10 PM			
3. SEX M		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 2-2-09		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.					
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T			
13a. STATE Md.				13b. COUNTY HARRIS		13c. CITY OR TOWN HANOVER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST John Eldridge				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gray Harris							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WWW 705-09-6762		17. INFORMANT ADDRESS MABLE Eldridge Ridg Rd, Hanover, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Cardiovascular collapse DUE TO, OR AS A CONSEQUENCE OF (b) CHH DUE TO, OR AS A CONSEQUENCE OF (c) ASCVD + Septicemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 8/16/84 to 4/16/84, that (I) (we) lost saw the deceased alive on 8/16/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not see the body after death.											
22b. SIGNATURE ANASTASIO E. SUBONG, M.D.			DEGREE			22c. DATE SIGNED 4/16/84					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 206 CRAIN HIGHWAY, S. W. GLEN BURNIE, MARYLAND 21061								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/21/84			23c. NAME OF CEMETERY OR CREMATORY Madonridge Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE 7250 Washington Blvd		
24. FUNERAL DIRECTOR NAME Locke Funeral Home			ADDRESS 1304 N. Central			25a. DATE REC'D. BY REGISTRAR APR 19 1984				25b. REGISTRAR'S SIGNATURE	

BP

444-1-3 504

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 allows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 09105			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY Sarah ENGELMEYER				2a. DATE OF DEATH MONTH DAY YEAR 4-23-84			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 2-28-10		6. AGE (IN YEARS (LAST BIRTHDAY)) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL CO., MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sister(Nun) Catholic Church		12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE MD				13b. COUNTY AA		13c. CITY OR TOWN Annapolis	
14. FATHER'S NAME FIRST MIDDLE LAST Charles M. Engelmeyer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah G. Giblin		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
16b. SOCIAL SECURITY NO. 218722542		17. INFORMANT Sisters of Notre Dame - Annapolis MD 21401		18. ADDRESS 4 Shipwright St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY 4100 Myocardial Infarction - Shunt. IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arterio Sclerotic Disease DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 22 April 1984 to 23 April 1984 , that (I) (we) last saw the deceased alive on 23 April 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Donald H. Hislop				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 23 April 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD H. HISLOP				22e. ADDRESS Robinson Rd & Owens Way, Severna Park, MD 21146			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 26, 1984		23c. NAME OF CEMETERY OR CREMATORY College of Notre Dame		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD				25a. DATE REC'D. BY REGISTRAR APR 26 1984			
				25b. REGISTRAR'S SIGNATURE Julia Davidson			

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09106

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) James Edward Eshleman			2a. DATE OF DEATH MONTH DAY YEAR April 29 1984		2b. HOUR A. M.
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Oct. 25, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS	IF UNDER 1 YEAR MONTHS DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel Co. MD.	
10. CITY OR TOWN OF DEATH Annapolis	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Anne Arundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Attorney		12b. KIND OF BUSINESS OR INDUSTRY Law
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MD	13b. COUNTY AA	13c. CITY OR TOWN Annapolis	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 2544 Carrollton Road 21403	
14. FATHER'S NAME FIRST MIDDLE LAST Elmer I. Eshleman		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Orpha Showe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE YEAR OR DATES) Yes WW II		16b. SOCIAL SECURITY NO. 219-20-1155		17. INFORMANT ADDRESS Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma 1991 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Diabetes mellitus and stop renal disease peripheral vascular disease					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from ~ 1981 , 19____, to 4-29 , 19 84 , that (I) (we) lost saw the deceased alive on 4-28 , 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (and) (not) view the body after death.					
22b. SIGNATURE G. M. Mitchell MD		DEGREE		22c. DATE SIGNED 4-30-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. MITCHELL MD		22e. ADDRESS 285 Ridgely Ave Annapolis MD 21401			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE May 1, 1984	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION CITY OR TOWN COUNTY STATE Fredenck Fredenck MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis. MD		ADDRESS		25a. DATE REC'D. BY REGISTRAR MAY 2 1984	
				25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 74 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4 AND 5 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 9107			
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) Andrew Chase Esteves										2a. DATE KNOWN OF DEATH		2b. HOUR	
3. SEX Male										4. RACE White		5. DATE OF BIRTH Nov. 1, 1983	
6. AGE (IN YEARS) 5 YRS. 4										7. DATE OF BIRTH		8. DATE OF DEATH	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.										9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9c. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Annapolis										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION Anne Arundel General Hospital		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None	
13a. STATE MD.										13b. CITY OR TOWN Edgewater		13c. STREET ADDRESS 301 Lakeview Ave. 21037	
14. FATHER'S NAME Albert C. Esteves										15. MOTHER'S MAIDEN NAME Sherry Adkins		16. WAS DECEASED EVER IN U.S. ARMED FORCES? No	
17. SOCIAL SECURITY NO.										18. INFORMANT Albert C. Esteves		19. ADDRESS #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 7980 IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .										TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER		DATE SIGNED 4/5/84	
ACTUAL SIGNATURE Gregory R. Kauffman, M.D.										EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201	
23a. BURIAL, CREMATION, REMOVAL Burial										23b. DATE 4/9/84		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery	
24. FUNERAL DIRECTOR Taylor Funeral Chapel										24b. ADDRESS Annapolis, MD.		24c. LOCATION CITY OR TOWN COUNTY STATE Brentwood, P.G. MD.	
RECORDED BY REGISTRAR'S SIGNATURE										DATE 4/11/84		SIGNATURE	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF CLERK. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOHN EDWARD FABIAN, Sr.		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 4 DAY 27 YEAR 1984		2b. HOUR 1930
3. SEX M	4. RACE W	5. DATE OF BIRTH MONTH 9 DAY 8 YEAR 11	6. AGE (IN YEARS) LAST BIRTHDAY 72 YRS.	IF UNDER 1 YR. MONTHS _____ DAYS _____
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH Glen Burnie		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Anundel General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Pipefitter Beth. Steel
13a. STATE Maryland		13b. COUNTY Anne Arundel	13c. CITY OR TOWN Pasadena	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST Bohumil MIDDLE James LAST Fabian		15. MOTHER'S MAIDEN NAME FIRST Caroline MIDDLE Deibal LAST Deibal		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-10-0260		17. INFORMANT Mrs. Lorraine P. Fabian ADDRESS Pasadena Md. 21122 8034 Belhaven Ave.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Heart Attack 4275 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE James E Wheeler		TITLE (SPECIFY) M.D. Dep		DATE SIGNED 4-27-84
EXAMINER'S NAME (TYPE OR PRINT) JAMES E WHEELER		ADDRESS 910 Primrose Rd Anne.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 5/1/84	23c. NAME OF CEMETERY OR CREMATORY Mount Olivet Cemetery	23d. LOCATION CITY OR TOWN Baltimore	COUNTY Maryland
24. FUNERAL DIRECTOR'S NAME McCutty Funeral Home of Pasadena		ADDRESS Mountain and Tick Neck Rds. Pasadena, Md. 21122		DATE MAY 2 1984
25. REGISTRAR'S SIGNATURE P. Davidson		DATE 4-27-84		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				09109	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) WALTER PAUL FALK			2a. DATE OF DEATH MONTH DAY YEAR 4 / 1 / 84		2b. HOUR 6 A M
3. SEX M	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR 9 / 2 / 62		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD	
10. CITY OR TOWN OF DEATH Brooklyn Heights	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Meridian Nursing Center - HAMMONDS LANE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver	12b. KIND OF BUSINESS OR INDUSTRY Trucking	
13a. STATE MD.	13b. COUNTY Baltimore	13c. CITY OR TOWN Lansdowne	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 927 Imperial Ct. 21227	
14. FATHER'S NAME FIRST MIDDLE LAST John Falk		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Elliott			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 215-05-1315		17. INFORMANT Audrey Vance; 925 Imperial Ct., Balt. 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4860 DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Michael Schwartz MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-2-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL SCHWARTZ		22e. ADDRESS 606 HAMMONDS LANE, BALTO MD 21225			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 4, 1984	23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Baltimore Md.
24. FUNERAL DIRECTOR NAME Howard H. Hubbard Funeral Home		Ave., Balt. 29 4107 Wilkens		25a. DATE REC'D. BY REGISTRAR APR 4 1984	25b. REGISTRAR'S SIGNATURE John Davidson-Randall

BP _____

Handwritten notes and a table on lined paper. The table has columns for 'Time' and 'Temperature'. The text is mostly illegible due to blurring and bleed-through.

Handwritten notes and a table on lined paper. The table has columns for 'Time' and 'Temperature'. The text is mostly illegible due to blurring and bleed-through.

Handwritten notes and a table on lined paper. The table has columns for 'Time' and 'Temperature'. The text is mostly illegible due to blurring and bleed-through.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show only injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

09110

1. DECEASED NAME (TYPE OR PRINT) MARY (NMN) FETTIG			2a. DATE OF DEATH MONTH DAY YEAR 4-8-84			2b. HOUR 1:10 PM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 10 06		6. AGE (IN YEARS LAST BIRTHDAY) 77		7. YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. DAKOTA		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.			
11. CITY OR TOWN OF DEATH CROFTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CROFTON CONVALESCENT CNTR.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEMAKER		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Wisconsin		13b. COUNTY Milwaukee		13c. CITY OR TOWN Waterford		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 27142 Sherwood Forest Drive 53185	
14. FATHER'S NAME FIRST MIDDLE LAST Pius Moser				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Regina Glass					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 391-48-8077		17. INFORMANT ADDRESS 27142 Sherwood Forest Drive Waterford, Wisconsin 53185					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left ventricular failure 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebrovascular accident DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Months years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: NO									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3/21 84 to 4/8 84			
22a. I certify that (I) (this hospital) attended the deceased from 4/8 84 to 4/8 84 , that (I) (we) lost saw the deceased alive on 4/8 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE MAX C FRANK MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/9/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MAX C FRANK MD			22e. ADDRESS 7575 Ritchie Hwy - Glen Burnie MD 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 12, 1984		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION (CITY OR TOWN) COUNTY STATE Milwaukee, Milwaukee, Wisconsin			
24. FUNERAL DIRECTOR NAME Beall Funeral Home				16000 Annapolis Road Bowie, Maryland 20715		25a. DATE REC'D. BY REGISTRAR APR 9 1984		25b. REGISTRAR'S SIGNATURE Jana Davidson-Rodwell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09111

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT)		FIRST EDWARD	MIDDLE HOUSTON	LAST FITZGERALD, Sr.	2a. DATE OF DEATH MONTH DAY YEAR APRIL 9, 1984		2b. HOUR 240 AM	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 1 1908		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH GLEN BURNIE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Catering		12b. KIND OF BUSINESS OR INDUSTRY Retired		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE California		13b. COUNTY N/A	13c. CITY OR TOWN Norwalk	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 11102 Excelsior Drive 90650			
14. FATHER'S NAME FIRST MIDDLE LAST Ezard		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth N/A		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Edward H. Fitzgerald, Jr. Same as 13						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Un differentiated Cancer - RL</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Bronchopneumonia, bilateral</u>								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>Wallace and Fitzgerald septal defect, Pericardial Abscess</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>2/3</u> , 19 <u>84</u> , to <u>4/9</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>4/7</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Robert B. Kroopnick</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/10/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT B. KROOPNICK, M. D.		22e. ADDRESS 7422 BALTIMORE-ANNAPOLIS BLVD GLEN BURNIE, MARYLAND 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 11 April 84		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Baltimore MD		
24. FUNERAL DIRECTOR NAME James S. Kirkley, Glen Burnie, MD				25a. DATE REC'D. BY REGISTRAR APR 11 1984				



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09112

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RICHARD K FLISS			2a. DATE OF DEATH MONTH DAY YEAR 4 21 84			2b. HOUR 1805	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 1 1923		6. AGE (IN YEARS LAST BIRTHDAY) 60	
7a. BIRTHPLACE (STATE OR FOREIGN) Wise		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL MD.	
10. CITY OR TOWN OF DEATH ANNAPOHIS		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF HOME, GIVE STREET ADDRESS) A.A. Yen Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ANTIQUES		12b. KIND OF BUSINESS OR INDUSTRY DEALER	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY AA		13c. CITY OR TOWN ANNAPOHIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wink		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 39709 1933	
17. INFORMANT NAME ADDRESS JOHN J. FLISS 4612 GROVE ST. SKOKIE, ILL. 60076							

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **5712**

DUE TO, OR AS A CONSEQUENCE OF

(b) **CIRRHOSIS OF LIVER**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ALCOHOLIC LIVER DISEASE**

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
14 HOURS

YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

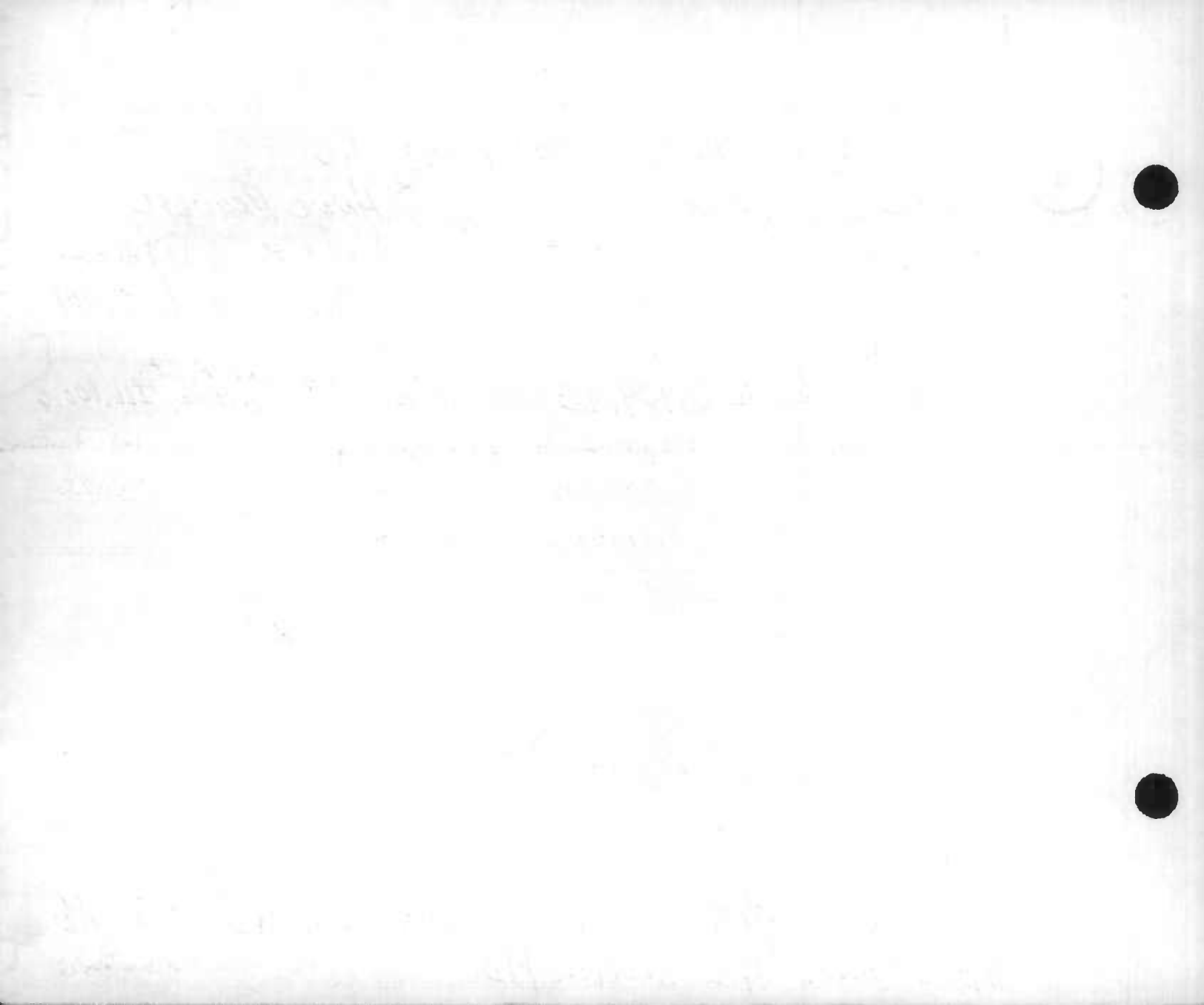
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 21 , 19 84 , to April 21 , 19 84 , that (I) (we) last saw the deceased alive on April 21 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Michael N. Peters		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/21/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL N. PETERS		22e. ADDRESS M.D. CATHEDRAL AND FRANKLIN STS.					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 5/1/84		23c. NAME OF CEMETERY OR CREMATORY CEDEAR HILL CENT.		23d. LOCATION CITY OR TOWN COUNTY STATE SKITHAND P.G. MD.	
24. FUNERAL DIRECTOR NAME TAYLOR FUNERAL CHAPEL		ADDRESS ANNAPOHIS, MD.		25a. DATE REC'D. BY REGISTRAR MAY 2 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Rodell	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09113

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Bernice M. Flynn</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>April 26, 1984</i>		2b. HOUR M <i>M</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>March 30, 1940</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>44</i>		
10. CITY OR TOWN OF DEATH <i>Pasadena</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>104 N. Carolina Ave. Pasadena, Md.</i>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>A.A.Co.</i>		
13a. STATE <i>Maryland</i>		13b. COUNTY <i>A.A.Co.</i>		13c. CITY OR TOWN <i>Pasadena</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>William E. Rapp</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Helen Gnachik</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Stock Clerk</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>213-36-4944</i>		17. INFORMANT ADDRESS <i>Mr. Joseph Flynn, Same as above</i>		
12b. KIND OF BUSINESS OR INDUSTRY <i>G.C. Murphy's</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>104 N. Carolina Ave. Pasadena, Md.</i>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <i>1519</i> IMMEDIATE CAUSE (a) <i>ADENOCARCINOMA OF THE STOMACH</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) _____			
DUE TO, OR AS A CONSEQUENCE OF (c) _____			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>JUNE 1</i> , 19 <i>84</i> , to <i>APRIL 26</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>APRIL 26</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>L.M. Jumanox</i>		22c. DATE SIGNED <i>M.D.</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>L.M. JUMANOX, M.D.</i>		22e. ADDRESS <i>CHURCH HOSPITAL; 100 N. Broadway</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/30/84</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <i>BALTO. MD 11237</i>	
24. FUNERAL DIRECTOR NAME ADDRESS <i>McCully Funeral Home, Mt. & Tickneck Rds. Pasadena</i>		25a. DATE RECEIVED BY REGISTRAR <i>MAY 1 - 1984</i>	
		25b. REGISTRAR'S SIGNATURE <i>Shea Davidson</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Facility to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "a", item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



RECEIVED
JAN 10 1940
U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

[illegible text follows]



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09114

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT) ROBERTA NMY FORD			2a. DATE OF DEATH MONTH DAY YEAR APRIL 28, 1984			2b. HOUR 0830 AM			
3. SEX Female		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR July 24 1909		6. AGE (IN YEARS LAST BIRTHDAY) 74		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE COUNTRY DISTRICT C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH ANNE ARUNDEL COUNTY MD.			
10. CITY OR TOWN OF DEATH GLEN BURNIE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH ARUNDEL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md			13b. COUNTY A.A		13c. CITY OR TOWN ANNAPOLIS		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Ford				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lorenna Dennis					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-12-1552		17. INFORMANT ADDRESS Charles Ford 31 College Creek Ter.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 21 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic Heart Disease</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4-28</u> , 19 <u>84</u> , to <u>4-28</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>4-28</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>Long S Hsu</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-28-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LONG S HSU, M.D.			22e. ADDRESS 7845 OAKWOOD ROAD, SUITE 104 GLEN BURNIE, MARYLAND 21061						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5-4-1984		23c. NAME OF CEMETERY OR CREMATORY Pine Lawn		23d. LOCATION CITY OR TOWN COUNTY STATE ANNAPOLIS A.A. Md		
24. FUNERAL DIRECTOR NAME C.E. Hicks			ADDRESS 47922 Forest Drive			25a. DATE REC'D. BY REGISTRAR MAY 4 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Rendall	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 410-354-1100.

APRIL 28, 1964 0830 AM

ROBERTA ANN FORD



AGE ADJUSTED CLOUTY

WEST WHEEL HOSPITAL

CLIN BIRNIE

1125 HANCOCK ST

CHICAGO, ILL

MD J. H. HANCOCK

Donor

Donor

Donor

Donor

1125 HANCOCK ST

CHICAGO, ILL

MD J. H. HANCOCK

8 AM

8 AM

8 AM

ATTACHED TO THE



7805 CARMON ROAD, SUITE 104

CHICAGO, ILLINOIS 60630

CHICAGO, ILLINOIS 60630

CHICAGO, ILLINOIS 60630

CHICAGO, ILLINOIS 60630

CHICAGO, ILLINOIS 60630

CHICAGO, ILLINOIS 60630

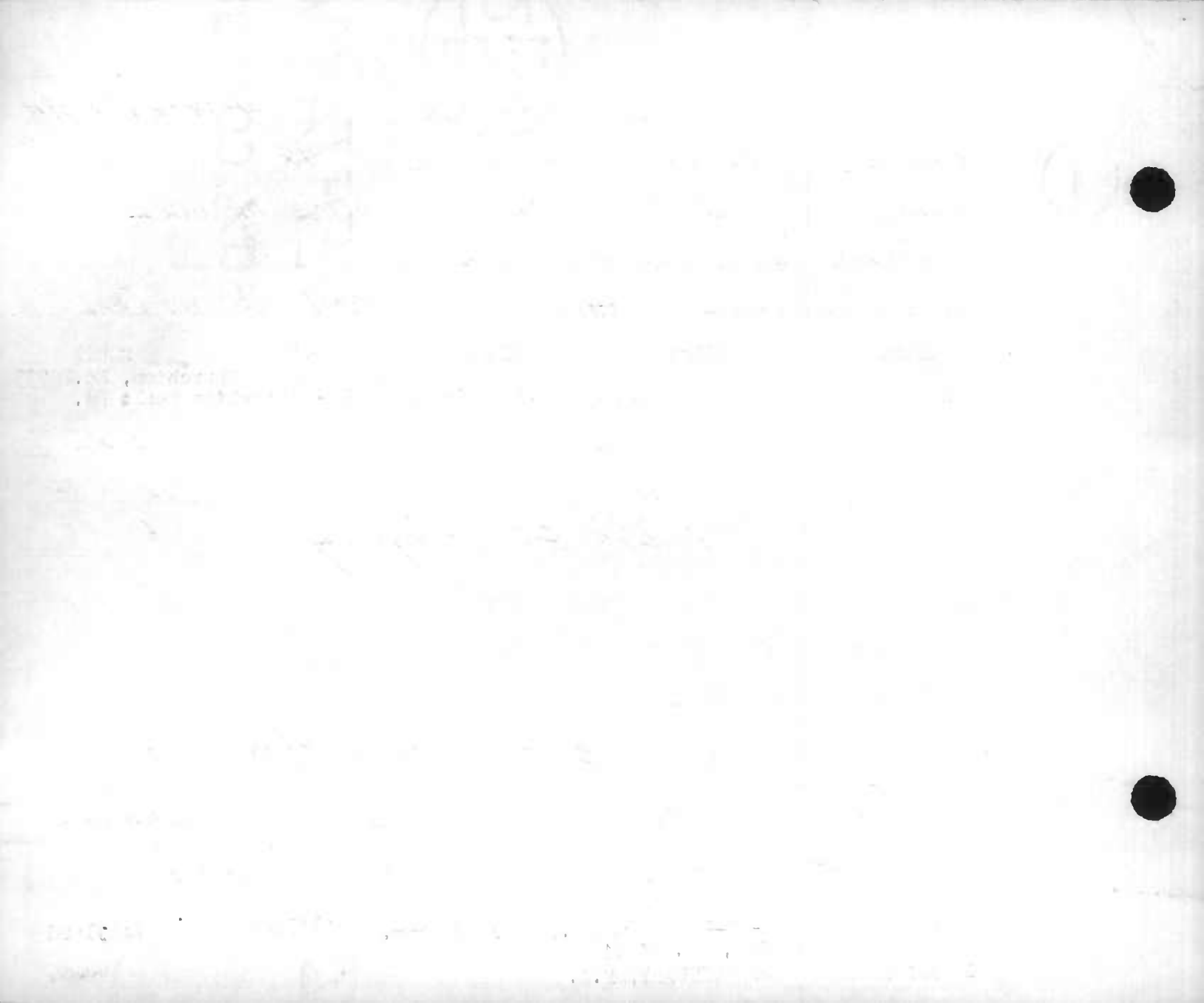
1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
LEE		FRANCES		FORRESTER				4-18-84		10:27 AM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
FEMALE		BLACK		8-27-05		78 YRS.		MONTHS		DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								
MARYLAND		USA				ANNIE ARUNDEL						MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY								
ANNAPOLIS		ANNIE ARUNDEL GENERAL HOSP												
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE		20733				
MD		ANNE ARUNDEL		CHURCHTON				5654 CHURCHTON DEAL						
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME												
FIRST MIDDLE LAST		FIRST MIDDLE LAST												
LEWIS		BLUNT												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS								
NO		579-44-0467		ELMER THOMPSON		5654 Churchton Deal Rd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART I. DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) CHF		2												
4292														
DUE TO, OR AS A CONSEQUENCE OF (b) ASCHO		10 1/2 +												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.														
DUE TO, OR AS A CONSEQUENCE OF (c) Probable GI malignancy		6												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1:														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from 4/17/84 to 4/18/84, that (I) (we) lost		19 76		4/18		19 84								
22b. SIGNATURE Harvey J. Steinfeld		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/18/84								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARVEY J. STEINFELD		22e. ADDRESS SHADYSIDE MD 20764												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4-23-84		23c. NAME OF CEMETERY OR CREMATORY BALTO., NATIONAL		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland								
24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A.		Annapolis, Md. 21401		25a. DATE REC'D. BY REGISTRAR 4 APR 26 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall								

DHMH - 16 50M 4/83
(VRA 15, 4)

25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
APR 26 1984	Lelia Davidson Bondell



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be placed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified of place.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09116

1- FOR
STATE
REGISTRAR

REG. NO.

EST

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	MONTH	DAY	MIN.
RICHARD EARL FRADY			APRIL 25, 1984			730 PM		
3 SEX	4 RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Caucasian	April 15, 1920		64 YRS.		MONTHS		DAYS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Montana	USA			ANNE ARUNDEL COUNTY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
GLEN BURNIE	NORTH ARUNDEL HOSPITAL			Rancher		Cattle		

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE		
13a. STATE			13b. CITY OR TOWN			13c. STREET ADDRESS / ZIP CODE		
Wyoming			Clearmont			Box 66 82835		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			ADDRESS		
John Earl Frady			Hazel Maben			332 Red Magnolia Ct.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT		
NO			516-18-4730			Marge Glennan Millersville MD 21108		

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:		
IMMEDIATE CAUSE (a) Cardio respiratory arrest		
4100 DUE TO, OR AS A CONSEQUENCE OF		
(b) Acute Myocardial Infarction		
DUE TO, OR AS A CONSEQUENCE OF		
(c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Basant K. Khandelwal				M.D.		4/26/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
BASANT K. Khandelwal, M.D.				7422 BALTIMORE-ANNAPOLIS BLVD. GLEN BURNIE, MARYLAND 21061			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial				Jordan		miles City MT	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR			
Taylor Funeral Chapel - Annapolis, MD				MAY 2 1984			
ADDRESS				REGISTRAR'S SIGNATURE			
				Julia Davidson-Randall			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. OR VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH ESTIMATED		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
Kevin		M.		Franklin			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD	2d. HOUR
Male	Cauc.	Dec. 2, 1964	19 YRS.			4/7/84	9:45 A M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Chicago, Illinois	USA				Anne Arundel County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Annapolis	Substation off Service Rd. On Taylor St.				Elec. Power		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS		
Maryland		Anne Arundel	Annapolis		21401 123 Prince Georges Street		
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
LEE L. FRANKLIN		MARIJO CITRO					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No		225-21-3470		Lee Franklin 3 Richardson Way Piedmont, CALIF.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Electrocution</u> 9257 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 4/7/84		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
				subject electrocuted			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
		power transformer		Sub Station on Taylor St., Annapolis, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 4/8/84	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
Gregory R. Kauffman, M.D.		111 Penn St., Balto., Md. 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial	4/10/84	National Memorial Park		Falls Church, Fairfax VA			
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Murphy - Falls Church 1102 W. Broad St. Falls Church, VA.		APR 16 1984		John Davidson			

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RECEIVED

APR 10 1964

APR 10 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09118

FOR 1 - STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Edward M. Frohlich, Sr.		2a. DATE OF DEATH MONTH DAY YEAR April 3, 1984	
3. SEX Male		2b. HOUR 9:30A.M.	
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Dec. 23, 1907	
6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD.	
10. CITY OR TOWN OF DEATH Annapolis		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) Anne Arundel General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. CITY OR TOWN A.A. Deale	
13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS ZIP CODE 6005 Parker Drive 20751	
14. FATHER'S NAME George		15. MOTHER'S MAIDEN NAME Rachel Mae Porter	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-07-6551	
17. INFORMANT Mrs. Bessie C. Frohlich		ADDRESS Address Same as No# 13c.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASCVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a.			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>81</u> to <u>March</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>3 MARCH</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>William P. Jones, MD</u>		22c. DATE SIGNED 3 Apr 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) William P. Jones, MD		22e. ADDRESS 4837 Solomons Isl Rd. Luthier	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 6, 1984	
23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME F. Gasch's Sons F.H. P.A. Hyatts. Md. 20781		25a. DATE REC'D. BY REGISTRAR APR 6 1984	
25b. REGISTRAR'S SIGNATURE <u>Julia Davidson</u>			



BP

DHMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Robert Frances Gebhardt Sr.			2a. DATE OF DEATH		MONTH DAY YEAR HOUR	
			4 4 84		P M	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR July 24, 1921		6. AGE (IN YEARS LAST BIRTHDAY) 62		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD.		
10. CITY OR TOWN OF DEATH Edgewater		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3506 Indian Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U.S. Navy (Ret.)		12b. KIND OF BUSINESS OR INDUSTRY Defense
13a. STATE MD.	13b. COUNTY A.A.	13c. CITY OR TOWN Edgewater	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3506 Indian Lane 21037		
14. FATHER'S NAME FIRST MIDDLE LAST Erich Alfred Gebhardt		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ann Kipling				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1962-1966 579-14-0633		17. INFORMANT ADDRESS Margaret Ann Gebhardt #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1850 IMMEDIATE CAUSE (a) Cancer prostate, metastatic DUE TO, OR AS A CONSEQUENCE OF (b) (Attending physician) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) James De Haven, Walter Reed Hosp.)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Stuart E. Selonick, M.D.				DEGREE M.D.		22c. DATE SIGNED 4/6/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stuart E. Selonick, M.D.				22e. ADDRESS 51 Franklin St. Annapolis Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Apr. 6, 1984		23c. NAME OF CEMETERY OR CREMATORY Lakemont Cemetery Davidsonville A.A. MD.		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel Annapolis, MD.				25a. DATE REC'D. BY REGISTRAR APR 11 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall

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9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09120

REG. NO.

| | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GLADYS Louella GORE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 18, 1984 | | | 2b. HOUR
M
M | | | |
| 3 SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 9, 1922 | | 6 AGE (IN YEARS LAST BIRTHDAY)
61 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | |
| 10 CITY OR TOWN OF DEATH
Pasadena | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1526 Marco Drive | | | | 12a USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
wire person | | 12b. KIND OF BUSINESS OR INDUSTRY
Westinghouse | |
| 13a STATE
Maryland | | 13b. COUNTY
A..A | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS, / ZIP CODE
203 Buckingham Drive 21061 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis C. Phillips | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Florence C. Preston | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218/18/3709 | | 17. INFORMANT (Son)
Mr. W. Ronald Gore | | ADDRESS 1526 Marco Drive Pasadena, 21122 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1579 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Dehydration, Malnutrition
DUE TO, OR AS A CONSEQUENCE OF
(c) Cancer of Pancreas | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/29/84 , 19____, to 4/1/84 , 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. John L. Cameron | | | | 22e. ADDRESS
Johns Hopkins Hospital
Baltimore, Maryland | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
April 21, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Prk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME <i>[Signature]</i> ADDRESS
Singleton Funeral Home Glen Burnie, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
APR 24 1984 | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | |

BP



RECEIVED

April 1, 1964

JOHN ARWOLD

WIDE PAVEMENT

11.11.11

11.11.11

Handwritten

Handwritten

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified by the funeral director.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09121

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Helen E Greenlaw | | | 2a. DATE OF DEATH
MONTH DAY YEAR April 28 1984 | | | 2b. HOUR
MIN. 5:45A | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR April 21 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Titusville, Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH
Shady Side | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4913 Hine Drive | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
household | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Shady Side | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
4913 Hine Dr. | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Herman C. Edwards | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ada Austin | | ADDRESS 14803 Pratt St. Upper Marlboro, Md. | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
579-60-3208 | | 17. INFORMANT
James R. Bucher | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease
4292
DUE TO OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
No injury | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET
8/15/79 | | 21g. CITY OR TOWN
4/28 | | 21h. COUNTY
84 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/27/84 to 4/28 19 84 , the (I) (we) last saw the deceased alive on 4/27/84 19 84 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Charles H. Wirth MD | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/28/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles H. Wirth MD | | 22e. ADDRESS
Lothian, Md 20711 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Entombment | | 23b. DATE
4/30/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft Lincoln | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. Co. Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Hardesty Fuenral Home | | ADDRESS
12 Ridgely Ave Annapolis, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 1 - 1984 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

BP

From the
Library of the
University of Chicago
Chicago, Ill.
1902

Received of
the University of Chicago
Library

1902
1902
1902

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 09122 | | | |
|--|--|--|--|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST
MAMIE D. GREMPLER | | | | April 12, 1984 10:30P | | | |
| 3 SEX
Female | | 4 RACE
White | | 5 DATE OF BIRTH MONTH DAY YEAR
March 20, 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 74 HRS
94 YRS MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | |
| 10 CITY OR TOWN OF DEATH
Pasadena | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
263 Eagle Hill Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Pasadena | |
| 14 FATHER'S NAME FIRST MIDDLE LAST
Charles Dankmeyer | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Caroline Ohle | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
213-50-0650 | | 17 INFORMANT ADDRESS
Beverly G. Looper Same as # 13 | | | |
| 18 CAUSE OF DEATH (Enter only one cause on line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE
4292 Cardiac decompensation due to ASCVD | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
none | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from September 2, 1983, to April 12, 1984, that (I) (we) saw the deceased alive on April 12, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
R. M. McLaughlin, M.D. | | | | DEGREE | | 22c. DATE SIGNED
4/12/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
McLaughlin | | | | 22e. ADDRESS
33708 Mount Airy Rd. Pasadena, Md. 21122 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/16/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Lorraine Park Cemetery Woodlawn | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Md. | |
| FUNERAL HOME NAME
Leroy M. & Russell C. Witzke Funeral Homes P.A. | | | | 25. DATE REC'D. BY REGISTRAR'S SIGNATURE
APR 16 1984 Jena Davidson-Randall | | | |
| 1630 Edmondson Avenue, Catonsville, Md. 21228 | | | | | | | |

BP



| | | | | |
|----------|--------------------------|---------------------|------------------------|------------------------|
| Yamaha | White | March 22, 1990 | SA | April 12, 1984 10:3012 |
| Landmark | U.S.A. | Y | Alamo Municipal County | |
| Landmark | 203 Eagle Hill Road | Honolulu | Don Jones | |
| Landmark | Alamo Municipal Landmark | 203 Eagle Hill Road | 21122 | |
| Charles | Landmark | Landmark | Charles | |
| no | 2-2-0-0-0 | Jerry G. Jones | June 13 | |

1030 Robinson Avenue, Cantonville, AL 36928
Jerry G. Jones, 21122
Honolulu, 21122

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09123

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Richard Edward Gunther Sr | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 27 84 | | | 2b. HOUR
427/A | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
2 12 05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Baltimore, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Co. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
owner-operator | |
| 13a. STATE
Md. | | 13b. COUNTY
Queen Anne | | 13c. CITY OR TOWN
Queenstown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
Box 252 Rte 1 | | 13f. ZIP CODE
21658 | | | | | |

| | | | | | |
|---|--|---|--|--|--|
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Robert C. Gunther | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maude Pruitt | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
215-05-4527 | | 17. INFORMANT
ADDRESS
Box 252 Rte 1
Queenstown, Md. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4310

IMMEDIATE CAUSE (a)

Left occipital cerebral hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

(b) **Atherosclerosis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**3 days****many years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

None

| | | | | | | | |
|--------------------------------------|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION
--- | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
--- | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
|--------------------------------------|--|--|--|--|--|--|--|

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
|--|--|---|--|--|--|--|--|

| | | | | | |
|--|--|--|--|---|--|
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
|--|--|--|--|---|--|

| | | | | | |
|--|--|--|--|--|--|
| 22a. I certify that (I) (this hospital) attended the deceased from 19 72 , to April 27 , 19 84 , that (I) (we) lost
saw the deceased alive on April 26 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
|--|--|--|--|--|--|

| | | | | | | | | |
|--|--|--|---|--|--|---|--|--|
| 22b. SIGNATURE
Charles W. Kinzer | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
April 29, 1984 | | |
|--|--|--|---|--|--|---|--|--|

| | | | | | | | | |
|--|--|--|--|--|--|--|--|--|
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHARLES W. KINZER MD | | | 22e. ADDRESS
ANNAPOLIS, MARYLAND | | | | | |
|--|--|--|--|--|--|--|--|--|

| | | | | | | | |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4/30/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Quaker Cemetary | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Galesville, Md. | |
|---|--|-----------------------------|--|--|--|--|--|

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 24. FUNERAL DIRECTOR
NAME
Hardesty Funeral Home | | ADDRESS
12 Ridgely Ave. Ann. Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 1 - 1984 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |
|--|--|--|--|--|--|--|--|

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified.

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09124

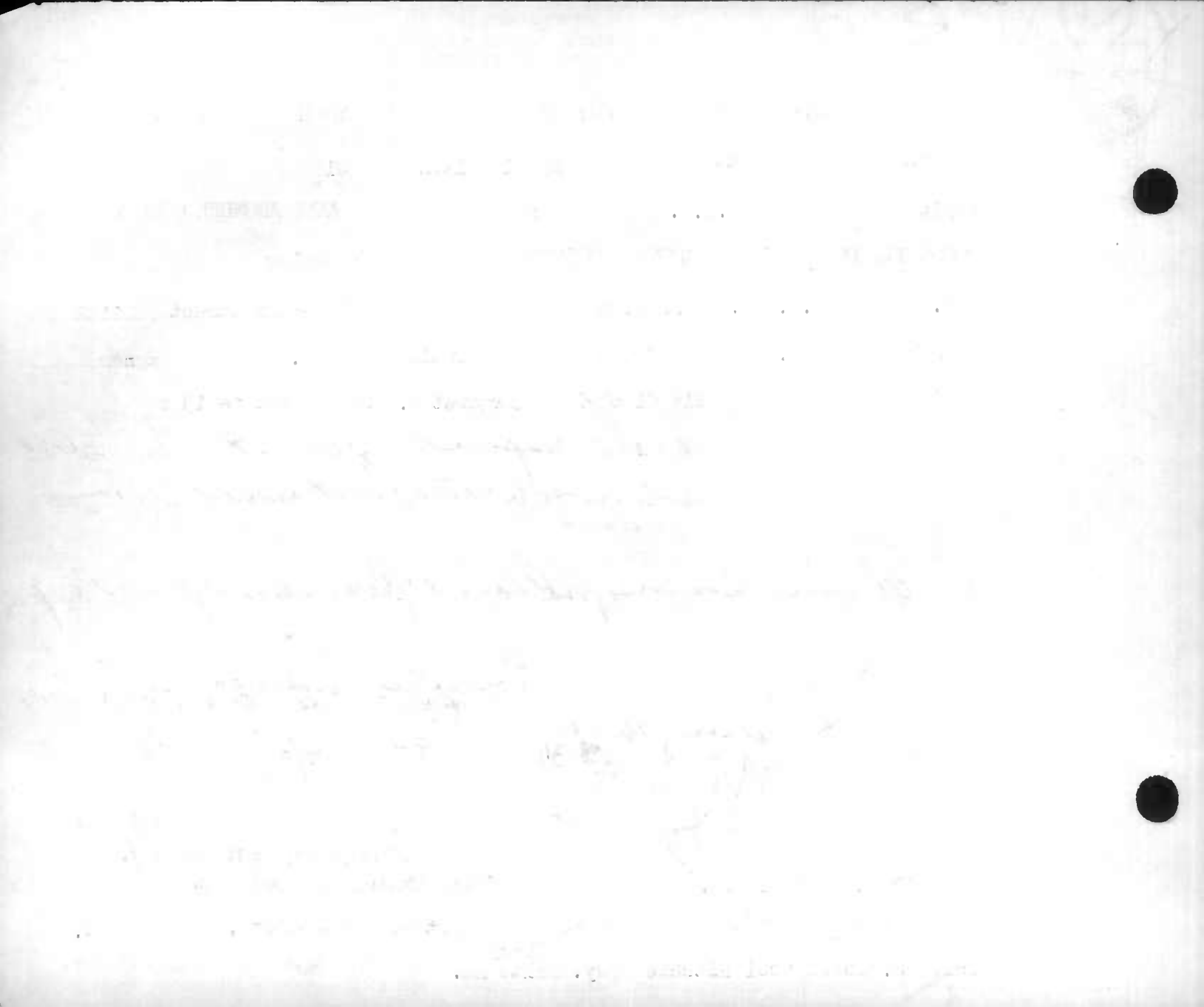
FOR
1 - STATE
REGISTRAR

REG. NO.

EST

| | | | | | | | | |
|---|--|--|---|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MINNIE M GUYTON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 2, 1984 | | | 2b. HOUR
246 AM | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 16 1902 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. STATE
Md. | | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John H. Gude | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie M. Hagner | | | 13e. STREET ADDRESS / ZIP CODE
487 Center Street 21122 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
218 01 8397 | | 17. INFORMANT
ADDRESS
Margaret M. Wooden Same as 13 e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest
4140
DUE TO, OR AS A CONSEQUENCE OF
(b) arteriosclerotic heart disease
DUE TO, OR AS A CONSEQUENCE OF
(c) Chronic Brain Syndrome; Chronic Generalized Epilepsy
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Immediate
Chronic | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
Precipitous unknown. Pathologic fracture due to osteoporosis | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
During Hand. | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Glen Burnie, Maryland | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/31/84 to 4/2/84 , that (I) (we) lost saw the deceased alive on 4/2/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
John S. Decker, M.D. | | | 22c. ADDRESS
325 HOSPITAL DRIVE ROOM 109 GLEN BURNIE, MARYLAND 21061 | | | 22d. DATE SIGNED
4/2/84 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
4/5/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Md. | |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce | | | 25. ADDRESS
4001 Ritchie Hwy. Balto Md. | | | 25a. DATE REC'D. BY REGISTRAR
APR 4 1984 | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | | | | |

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (1))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|---------|---|-------------------|---|---------------------|---------------------------------------|----------|
| 1. FOR STATE REGISTRAR | | 7a. DATE KNOWN OF DEATH | | 8. MONTH DAY YEAR | | 9. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | |
| EDWARD | | J | | HAGNER | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. DATE PRONOUNCED DEAD | 10. HOUR |
| M | W | 3 21 24 | 60 YRS. | | | 4 18 84 | 2100 |
| 11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 12. CITIZEN OF WHAT COUNTRY? | | 13. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 14. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | UNITED STATES | | | | ANNE ARUNDEL MD. | |
| 15. CITY OR TOWN OF DEATH | | 16. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 17. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 18. KIND OF BUSINESS OR INDUSTRY | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | TRUCK DRIVER | | SELF EMPLOYED | |
| 19. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADDRESS) | | 13a. STATE | | 13b. CITY OR TOWN | | 13c. CITY OR TOWN | |
| MARYLAND | | ANNE ARUNDEL | | PASADENA | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16. STREET ADDRESS | | 17. CITY OR TOWN | |
| ELMER F. HAGNER, SR. | | ROSE E. LANAHAN | | ARMIGER RD. | | 21122 | |
| 18a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 18b. SOCIAL SECURITY NO. | | 19. INFORMANT | | 20. ADDRESS | |
| YES | | WW II | | 218-18-6221 | | JAMES HAGNER | |
| 21. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | 22. PART I DEATH WAS CAUSED BY: | | 23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 4100 | | IMMEDIATE CAUSE (a) Hunt attack | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (b) | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (c) | | | | | |
| 24. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 25a. DATE OF OPERATION | | 25b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 26. AUTOPSY? | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 27a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | P.M. 19 | | | | | |
| 28a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | 28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 28c. LOCATION | | | |
| | | | | STREET CITY OR TOWN COUNTY STATE | | | |
| 29. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | |
| 30. ACTUAL SIGNATURE | | 31. TITLE (SPECIFY) | | 32. MEDICAL EXAMINER | | 33. DATE SIGNED | |
| JAMES E. WHEELER | | M.D. Dep. | | | | 4-18-84 | |
| 34. EXAMINER'S NAME (TYPE OR PRINT) | | 35. ADDRESS | | 36. CITY OR TOWN | | 37. COUNTY | |
| JAMES E. WHEELER | | 910 Primrose | | Annapolis | | | |
| 38a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 38b. DATE | | 38c. NAME OF CEMETERY OR CREMATORY | | 38d. LOCATION | |
| BURIAL | | APRIL 21, 1984 | | CEDAR HILL CEMETERY | | BALTIMORE ANNE ARUNDEL MD. | |
| 39. FUNERAL DIRECTOR NAME | | 40. ADDRESS | | 41. DATE REC'D. BY REGISTRAR | | 42. REGISTRAR'S SIGNATURE | |
| ROBERT S. BARRANCO | | 4301 RITCHIE HWY. SEVERNA PARK, MD. | | APR 23 1984 | | Julia Davidson-Randall | |

EXHIBIT 1
PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

PLANT INDUSTRY
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09126

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <u>Leola M. Hair</u> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<u>April 15, 1984</u> | | | 2b. HOUR
<u>11 42</u> M | |
| 3. SEX
<u>Female</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<u>August 6 1901</u> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<u>82</u> YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<u>Virginia</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<u>Anne Arundel</u> MD. | |
| 10. CITY OR TOWN OF DEATH
<u>Annapolis</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<u>Anne Arundel General Hospital</u> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<u>telephone operator sales</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<u>Md.</u> | | 13b. COUNTY
<u>A.A. Co.</u> | | 13c. CITY OR TOWN
<u>Edgewater</u> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET ADDRESS / ZIP CODE
<u>309 Holly Rd. 21037</u> | | 13f. FATHER'S NAME
FIRST MIDDLE LAST
<u>Charles Stevens</u> | | 13g. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<u>MARY Isabelle Horstman</u> | | 13h. ADDRESS
<u>608 Overhill Dr. 21037</u> | |
| 14a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<u>no</u> | | 14b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<u>577-01-9688</u> | | 14c. INFORMANT
<u>Charles Marks</u> | | 14d. ADDRESS
<u>Edgewater, Md.</u> | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pneumonia,
4409
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF
(b) Constrictive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c) Arterio sclerosis -

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

2-3 days
chronic.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cu glitens, Renal ascens - Nephrosing tub

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<u>4/15</u> <u>7</u> <u>19</u> <u>84</u>
P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/>
AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE
<u>4/15</u> <u>84</u> | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>4/15</u> <u>19</u> <u>84</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<u>Rodney C Brinkley</u> | | | | 22c. DATE SIGNED
<u>4/16/84</u> | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | |
| 22e. ADDRESS
<u>12 Ridgely Ave.</u> | | | | 22f. DATE REC'D. BY REGISTRAR
<u>APR 17 1984</u> | | 22g. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | |

| | | | | | | | |
|---|--|---------------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<u>Burial</u> | | 23b. DATE
<u>April 18, 84</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Cedar Hill Cemetery Suitland</u> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<u>Md.</u> | |
| 24. FUNERAL DIRECTOR
NAME
<u>Hardesty Funeral Home</u> | | 24a. ADDRESS
<u>Ann. Md. 21401</u> | | 24b. DATE REC'D. BY REGISTRAR
<u>APR 17 1984</u> | | 24c. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Item 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09127

EST

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
BERNARD THOMAS HARTLOVE Sr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 28 1984 | | | 2b. HOUR
1035 PM | | | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 1, 1925 | | 6. AGE (IN YEARS LAST BIRTHDAY)
58 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | 8. IF UNDER 24 HRS
HOURS MIN.
00 00 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
Baltimore, Md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Owner | | | 12b. KIND OF BUSINESS OR INDUSTRY
Electric Buss. | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
A.A.. | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
711 Westley Street 21061 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John E. Hartlove | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine Bell | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W.II | | 17. INFORMANT (Wife) ADDRESS
Mrs. Thelma Hartlove | | | Same as #13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4274 IMMEDIATE CAUSE (a) Cardio respiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Ventricular arrhythmia
DUE TO, OR AS A CONSEQUENCE OF
(c) Lymphocytic lymphoma | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (II) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
Basant K. Khandelwal DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
4/29/84 | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BASANT K. KHADELWAL, M.D. | | | | | | 22e. ADDRESS
7422 BALTIMORE-ANNAPOLIS BLVD.
GLEN BURNIE, MARYLAND 21061 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
May 2, 1984 | | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Prk. Glen Burnie A.A. Md. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | |
| 24. FUNERAL DIRECTOR
Singleton Funeral Home Glen Burnie, Md | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 1 1984 | | | | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or medical examiner, it should be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09128

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Johnnie L.J. Heard | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 2, 1984 | | | 2b. HOUR
P.M.
9:00 | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
January 31, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Alabama | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
716 Wimmer Rd. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Welder | | 12b. KIND OF BUSINESS OR INDUSTRY
Koppers | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
MD. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
716 Wimmer Rd. 21061 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Lemuel Heard | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Frances Shrader | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WW 2 | | 17. INFORMANT ADDRESS
Edith L. Heard ;same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) General Carcinomatosis
1629 DUE TO, OR AS A CONSEQUENCE OF Carcinoma of lung
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 yr
1 yr | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 17, 19 63, to Apr. 2, 19 84, that (I) (we) lost saw the deceased alive on Apr 2, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Joseph Taler M.D. | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Apr. 3, 1984 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph Taler M.D. | | | | | 22e. ADDRESS
95 Aquahart Rd. Glen Burnie MD. 21061 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
5 April 84 | | 23c. NAME OF CEMETERY OR CREMATORY
Friendship Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Pisgah Jackson Alabama | | |
| 24. FUNERAL DIRECTOR
NAME
James S. Kirkley F.H. Glen Burnie MD. | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 4 1984 | | 25b. REGISTRAR'S SIGNATURE
Gina Davidson-Mendall | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARIE C HEISE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 26, 1984 | | 2b. HOUR
550 PM |
| 1. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Aug 11, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
91 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
Md. | | 13b. COUNTY
A.A. Co. | 13c. CITY OR TOWN
Pasadena | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Louis Carl Heise | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
216 05 1596 | | 17. INFORMANT ADDRESS
Ferd Fountain same as 13 e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4370 <i>Coronary Vascular Disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Generalized Atherosclerosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
<i>Arteriosclerosis Heart Disease & Chronic Shunt Abdomen</i> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Years
Years |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-26 , 19 84 , to 4-26 , 19 84 , that (I) (we) lost 4-26-84 the deceased above on 4-26 (did) (did not) see the body after death. | | | | | |
| 22b. SIGNATURE
<i>Hilary T. O'Herlihy</i> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4-26-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
HILARY T. O'HERLIHY, M. D. | | 22e. ADDRESS
325 HOSPITAL DRIVE SUITE 208
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/28/84 | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, Maryland |
| 24. FUNERAL DIRECTOR
NAME
George J. Gonce | | 24b. ADDRESS
4001 Ritchie Hwy Balto. Md. | | 25a. DATE REC'D. BY REGISTRAR
APR 30 1984 | |
| | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Randall</i> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

15 JUL 1964

UNITED STATES AIR FORCE

WALLACE FIELD

UNITED STATES AIR FORCE

WALLACE FIELD

UNITED STATES AIR FORCE

WALLACE FIELD

UNITED STATES AIR FORCE

WALLACE FIELD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH - 16 50M 4/83
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | | DST | | |
|--|--|---|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EARL W HESS | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 30, 1984 | | | 2b. HOUR
0412 PM | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov 5 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Foreman | | 12b. KIND OF BUSINESS OR INDUSTRY
MD State Airport | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
Maryland AA Severn | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
7776 Ricker Road 21144 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
N/A Hess | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
N/A | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-03-7348 | | 17. INFORMANT ADDRESS
Gwinn Hess, Box 1190, Freedom, Maine 04941 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute myocardial Infarction</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Previous myocardial Infarction</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>myocardial Ischemia</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18; PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 5</u> 19 <u>83</u> , to <u>June 8</u> 19 <u>83</u> , that (I) (we) lost
saw the deceased alive on <u>June 8</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>A R Sosnowski MD</u> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
5/1/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ANDREW R SOSNOWSKI MD | | | | | 22e. ADDRESS
4016 RITCHIE HIGHWAY
BALTIMORE, MARYLAND 21225 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5 May 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Lake View Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sykesville Carroll MD | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
James S. Kirkley, Glen Burnie, MD | | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
MAY 2 1984 Julia Davidson-Randall | | | | |

101



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | |
|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Archie Luthair Hicks | | | | 2a. DATE OF DEATH MONTH DAY YEAR April 27 1984 2b. HOUR 6A | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR December 18 1922 | |
| 6. AGE (IN YEARS (LAST BIRTHDAY)) 61 YRS. | | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iola Kansas | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD. | | 10. CITY OR TOWN OF DEATH Ft. Meade | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kimbrough Army Community Hospital | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired | | 12b. KIND OF BUSINESS OR INDUSTRY U.S. Army | | 13a. STREET ADDRESS 1309 Odenton Road | |
| 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. CITY OR TOWN Odenton | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Mont Hicks | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie Marley | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | |
| 16b. SOCIAL SECURITY NO. 510163296 | | 17. INFORMANT Deloris Hicks | | 17. ADDRESS 1309 Odenton Rd. Odenton, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4140 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF
(b) ASHD/COPO
DUE TO, OR AS A CONSEQUENCE OF
(c) DIABETES MELLITUS | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MINUTES
YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: DIABETES MELLITUS | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | 22a. I certify that (I) (this hospital) attended the deceased from 26 APRIL 19 84 to PRESERT 19 84 , that (I) (we) lost saw the deceased alive on 26 APRIL 19 84 and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE Rafael J. Igartua ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22c. DATE SIGNED 27 Apr 84 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Rafael J. Igartua, M. D. | | 22e. ADDRESS Kimbrough Army Community Hospital, Ft. Meade | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 4/30/84 | | 23c. NAME OF CEMETERY OR CREMATORY Crownsville VA Cem. Crownsville A.A.Co. Md | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE | | 24. FUNERAL DIRECTOR NAME hardesty Fuenral Home ADDRESS 12 Ridgely Ann. Md. 21401 | | 25a. DATE REC'D. BY REGISTRAR MAY 2 1984 25b. REGISTRAR'S SIGNATURE J. Davidson-Rendell | |

BP



Printed

1/30/84

Crownsville VA Cem. Crownsville A.S.C. 10

Valued 3. January, 1984

Lebanon Army Community Hospital, Lebanon

1984 1/30/84

Lebanon Army Community Hospital

17 Lebanon Road

Lebanon Army Community Hospital

Lebanon Army Community Hospital

December 15, 1983

Enclosure

Blank

Initials

Archive

April 27, 1984

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09132

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>Valeria P. Ignatenko</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>4 2 84</i> | | 2b. HOUR
<i>7 35 P</i>
M |
| 3. SEX
<i>Female</i> | 4. RACE
<i>White</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>6 30 94</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>89</i> YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Russia</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Anne Arundel</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Annapolis</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>Anne Arundel Gen. Hosp.</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Homemaker</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Home</i> |
| 13a. STATE
<i>MD</i> | | 13b. COUNTY
<i>AA</i> | 13c. CITY OR TOWN
<i>Beverly Park</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Peter Martini</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Theresa Demst</i> | | 16. ADDRESS
<i>Same as #13</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
<i>127-10-3791</i> | | 17. INFORMANT
<i>Alexis V. Pfeiffer</i> | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

1519
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Cerebral infarction

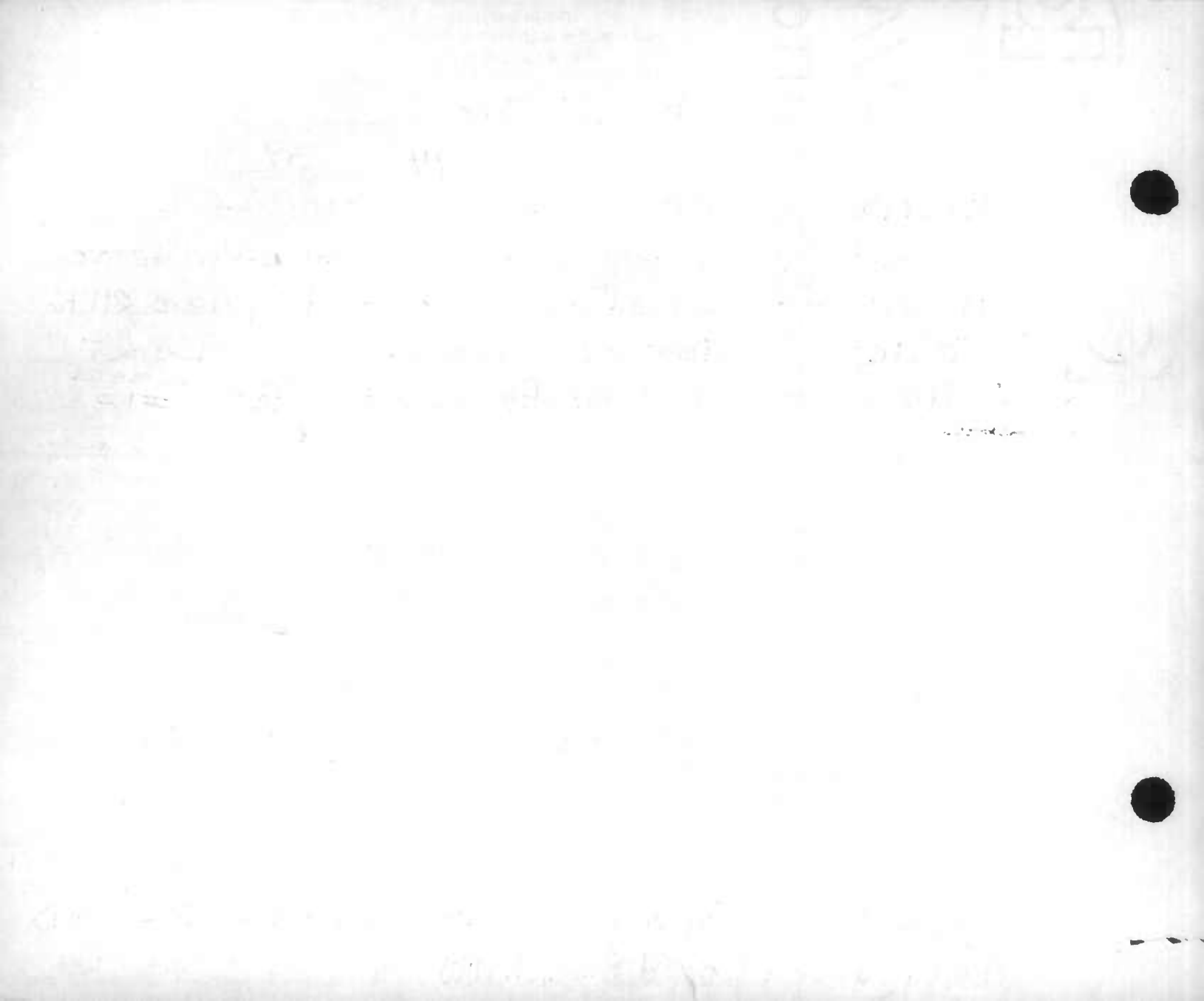
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

2 weeks.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>3/20/84</i> to <i>4/2/84</i> , that (I) (we) last saw the deceased alive on <i>4/2/84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>Gerard Blumel</i> | | DEGREE
<i>MD</i> | | 22c. DATE SIGNED
<i>14/3/84</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>Gerard Blumel</i> | | 22e. ADDRESS
<i>8 EVELYN BLVD. BOSTON, MA 02114</i> | | | |

| | | | |
|--|-----------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Cremation</i> | 23b. DATE
<i>April 4, 1984</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>Cedar Hill</i> | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Suitland P.G. MD</i> |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Taylor Funeral Chapel - Annapolis, MD</i> | | 25a. DATE REC'D. BY REGISTRAR
<i>APR 4 1984</i> | 25b. REGISTRAR'S SIGNATURE
<i>Johanna Davidson-Randall</i> |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

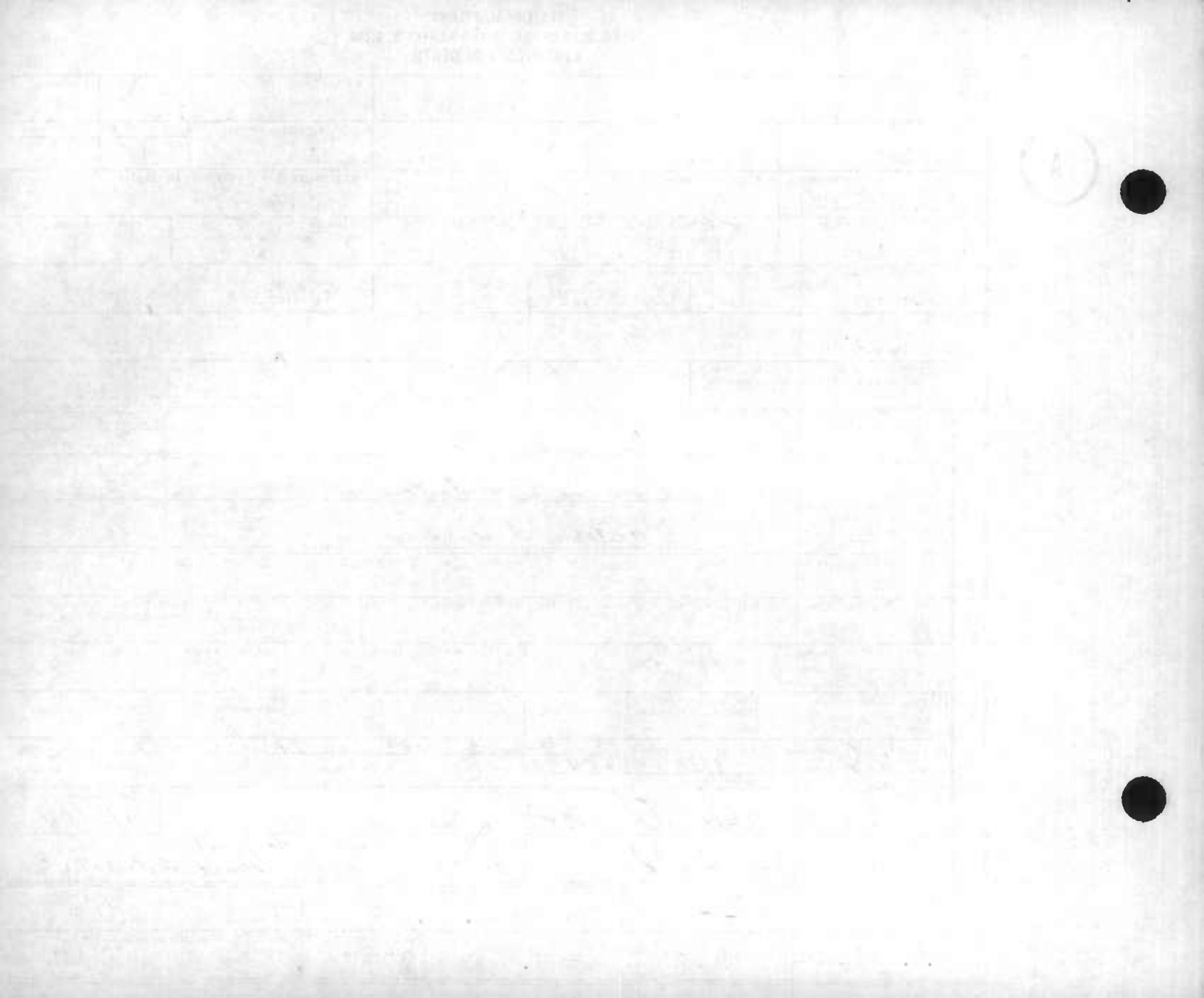
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|--|---|--|---|--|--|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | | | | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FRANCES A JACKSON | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 1 84 | | | 2b. HOUR
M | |
| 3 SEX
FEMALE | | 4 RACE
BLACK | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 27 1900 | | 6 AGE (IN YEARS LAST BIRTHDAY)
83 | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NORTH CAROLINA | | 7b. CITIZEN OF WHAT COUNTRY?
US | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH
CITY A. A. MD | | | |
| 10 CITY OR TOWN OF DEATH
GLEN BERNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
210 HENSON ROAD | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MARYLAND 13b. COUNTY 17A 13c. CITY OR TOWN GLEN BURNIE | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
210 HENSON ROAD 21061 | | |
| 14 FATHER'S NAME
FIRST MIDDLE LAST
Lantion | | | | | 15 MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary harfler | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS
ROBERT JACKSON 210 HENSON ROAD 21061 | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1719 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pulmonary Metastasis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Metastatic leiomyosarcoma</u> | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>Immediate</u>
<u>3 yrs</u>
<u>10 yrs</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>May 3, 1983</u> , to <u>April 1, 1984</u> , that (I) (we) last saw the deceased alive on <u>3/30</u> , 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Wm C Waterfield</u> | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> | | | 22c. DATE SIGNED
<u>4/3/84</u> | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Wm C Waterfield</u> | | 22e. ADDRESS
<u>St Agnes Hospital</u>
<u>900 Caton Ave</u>
<u>Balt Md 21229</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
4-4-84 | | 23c. NAME OF CEMETERY OR CREMATORY
ARBUTUS MEM. PK. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | | |
| 24 FUNERAL DIRECTOR
NAME
E.L. PHILLIPS 1721 NORTH MONROE ST. | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 3 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>Davidson-Rendell</u> | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

FOR
1 - STATE
REGISTRAR

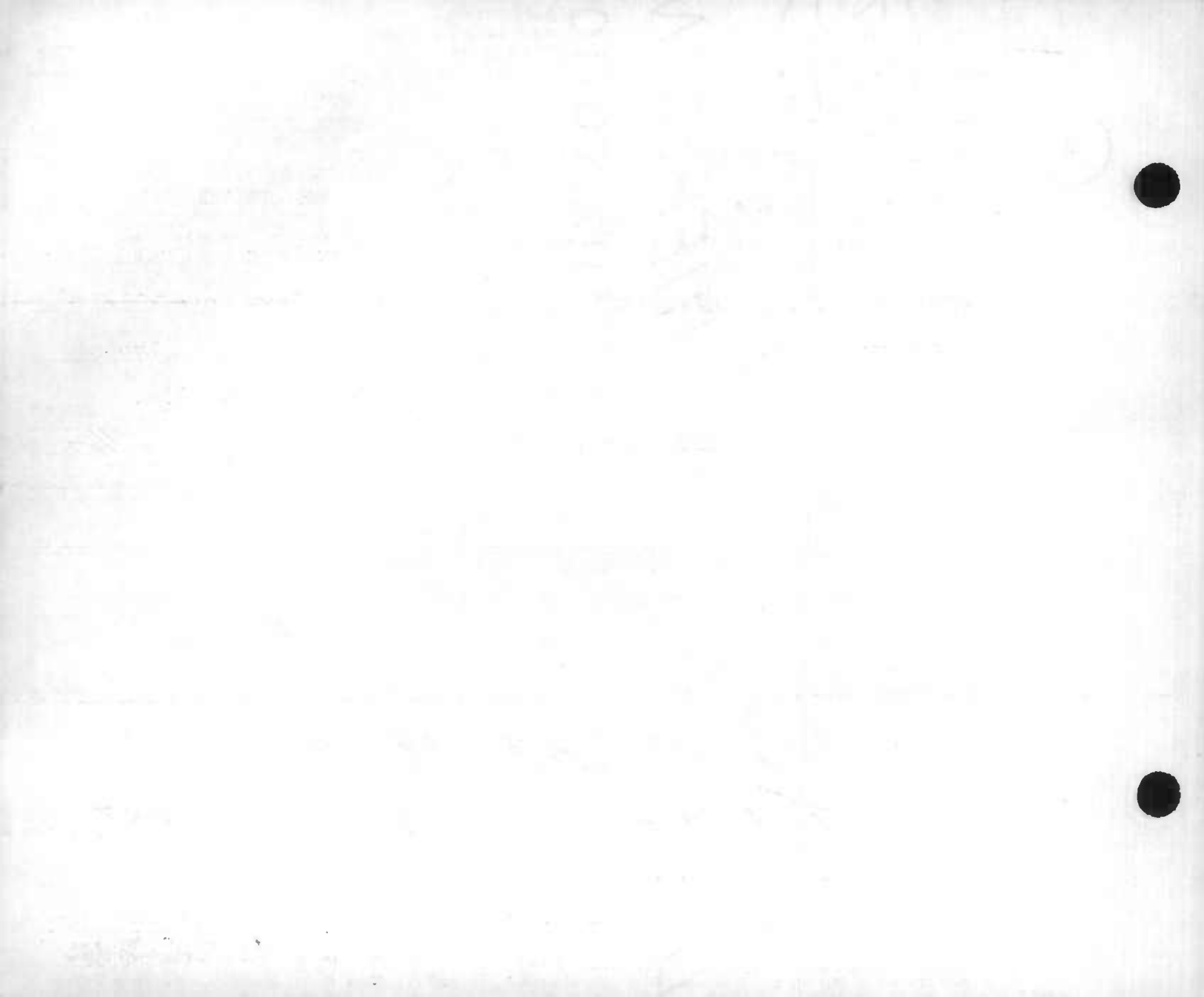
| | | | | | | | | | |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MILDRED GLADYS JAMES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 29, 1984 | | | 2b. HOUR
1219 AM | | | |
| 3. SEX
female | | 4. RACE
caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
8 31 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
83 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Merchant | | 12b. KIND OF BUSINESS OR INDUSTRY
Dress Shop | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Arthur J. Stewart | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Alda Lyons | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
218-34-7721 | | 17. INFORMANT
ADDRESS
Clarence G. James sameas 13e. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial INFARCT
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24hr | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/18/84 to 4/29/84, that (I) (we) lost
saw the deceased alive on 4-26-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
SERGIO V. ALVAREZ, M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
4/29/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS
300 HOSPITAL DRIVE, SUITE 134
GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
5-2-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Spring Hill | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Easton Talbot Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
Newnam Funeral Home | | | | ADDRESS
Easton, Md. | | 25a. DATE REC'D. BY REGISTRAR
MAY 2 1984 | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

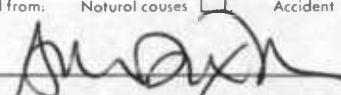
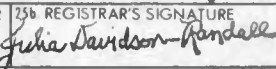
1. FOR
STATE
REGISTRAR

| | | | | | |
|--|------------------|--|--|---|------------------|
| 1. DECEASED NAME
(TYPE OR PRINT) ELIZABETH Mary JARBUE | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR HOUR
ESTIMATED <input type="checkbox"/> 04/10/84 6:01 PM | | |
| 3. SEX F | 4. RACE W | 5. DATE OF BIRTH
MONTH DAY YEAR 5/16/1073 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) YRS. 73 | IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | |
| 13a. STATE
Maryland | | 13b. COUNTY
Q.A. | | 13c. CITY OR TOWN
Stevensville | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Henry Seidlich | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Lyons | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | |
| 17a. SOCIAL SECURITY NO.
216-03-5534 | | 17. INFORMANT
George E. Jarboe, Stevensville, MD | | 17b. ADDRESS
21666 | |
| 18. CAUSE OF DEATH (Enter only one cause per line 1a (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4275 IMMEDIATE CAUSE (a) Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE
James E. Wheeler | | TITLE (SPECIFY)
Deputy | | DATE SIGNED
4-9-84 | |
| EXAMINER'S NAME
(TYPE OR PRINT)
JAMES E. WHEELER | | ADDRESS
910 Primrose Rd Annap. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
04/13/84 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Peter's Church | |
| 24. FUNERAL DIRECTOR
NAME
Tom Helfenbein | | ADDRESS
Buneral Home, Chester, MD | | 25a. DATE REC'D. BY REGISTRAR
APR 13 1984 | |
| 25b. REGISTRAR'S SIGNATURE
John Deaton | | 25c. COUNTY
Q.A. | | | |
| 25d. STATE
MD | | 25e. CITY OR TOWN
Queenstown | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHAMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|-------------------------|--|---|--|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Sherry D. Johnson | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 4 30 1984 | | 2b. HOUR M | | |
| 3. SEX FEMALE | | 4. RACE BLACK | | 5. DATE OF BIRTH
MONTH 11 DAY 28 YEAR 54 | | 6. AGE (IN YEARS)
LAST BIRTHDAY 29 YRS. | | IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County, MD. | | 2c. DATE PRONOUNCED DEAD 4 30 1984 | |
| 10. CITY OR TOWN OF DEATH Annapolis | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 408-A Boston Heights | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE MARYLAND | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN ANNAPOLIS | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 21401 408 A Boston Heights Circle | | | |
| 14. FATHER'S NAME
FIRST EDWARD MIDDLE JOHNSON LAST JOHNSON | | | | 15. MOTHER'S MAIDEN NAME
FIRST MILLIE MIDDLE JOHNSON LAST JOHNSON | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Apt. 33 Annapolis, Md. 21401
EDWARD JOHNSON 442 Boston Heights Circle | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Shotgun wound of head
9651
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 6 xxx 4 30 19 84 | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR 6 xxx 4 30 19 84 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | | | 21f. LOCATION
STREET 408-A Boston Hgts CITY OR TOWN Annapolis COUNTY A.A. STATE Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) Assistant MEDICAL EXAMINER | | | | DATE SIGNED 4/30/84 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D. | | | | ADDRESS 11 Penn St. Balto., MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 5-5-1984 | | 23c. NAME OF CEMETERY OR CREMATORY HILLCREST CEMETERY | | | 23d. LOCATION
CITY OR TOWN Annapolis COUNTY A.A. STATE Maryland | | |
| 24. FUNERAL DIRECTOR NAME WILLIAM REESE & SONS MORTUARY, P.A. | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 7 1984 | | 25b. REGISTRAR'S SIGNATURE  | | | |

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE



100 W. 1st St. N. Minneapolis, Minn.

100 W. 1st St. N. Minneapolis, Minn.

RECEIVED

100 W. 1st St. N.



100 W. 1st St. N. Minneapolis, Minn.

RECEIVED

100 W. 1st St. N.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|--|---|--|
| 1. FOR
STATE
REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| Charles Albert Jones | | 4/4/84 19 | | 8:15 P M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD |
| Male | White | Sept 23 07 | 76 YRS. | | 4/4/84 19 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED | NEVER MARRIED | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| California | USA | <input checked="" type="checkbox"/> | <input type="checkbox"/> | Anne Arundel County MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Edgewater | 827 Mayo Road | Electro Type | | Print | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | |
| Maryland | Anne Arundel | Edgewater | YES <input type="checkbox"/> NO <input type="checkbox"/> | 827 Mayo Road | 21037 |
| 14. FATHER'S NAME | 15. MOTHER'S MAIDEN NAME | 17. INFORMANT ADDRESS | | | |
| Albert Jones | Pearl Unknown | Lillian Jones Same as #13 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | | |
| No | 566 12 8438 | Lillian Jones Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Gunshot Wound to Head | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | |
| | | | | HEAD ONLY YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | |
| 4:28 P.M. 4/4/84 | | 4/4/84 19 | | self inflicted gunshot wound | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | |
| Bathroom | | 827 Mayo Road, Edgewater, Anne Arundel, Md. | | | |
| 22a. I certify that I took charge of the remains described above and that the death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | |
| Gregory R. Kauffman, M.D. | | M.D. Assistant | | 4/5/84 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | |
| Gregory R. Kauffman, M.D. | | 111 Penn St., Balto., Md. 21201 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION | COUNTY | STATE |
| Cremation | 6 April 84 | Cedar Hill Crematory | Suitland | Maryland | |
| 24. FUNERAL DIRECTOR NAME | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Robert E Wilhelm Funeral Home | | APR 10 1984 | | John Wilhelm | |
| Suitland Maryland | | | | | |



RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

APR 1 0 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) NATHANIEL H. JONES | | | 2a. DATE OF DEATH
MONTH DAY YEAR 4-22-84 2b. HOUR 12:35 AM | | |
| 3. SEX
M | 4. RACE
CAUCASIAN | 5. DATE OF BIRTH
MONTH DAY YEAR 3 24 01 | 6. AGE (IN YEARS LAST BIRTHDAY)
83 -79 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PA. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
A.A. County MD. | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
N. ARUNDEL CNY. CTR. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Salesman-Pitts. | 12b. KIND OF BUSINESS OR INDUSTRY
Steel Co. | |
| 13a. STATE
Md. | | 13b. COUNTY
Howe | 13c. CITY OR TOWN
Ellicott City | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Nathan Jones | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Fox | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO.
193-05-1670A | | 17. INFORMANT
2214 Mount Hebron Dr.-Ellicott City, Md. 21043 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4280 IMMEDIATE CAUSE (a) Respiratory failure
DUE TO, OR AS A CONSEQUENCE OF:
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF:
(c) chronic congestive heart failure
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-4 mins | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from 5/09 , 19 80 , to 4/22 , 19 84 , that (we) last saw the deceased alive on 4/22 , 19 84 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (b) <input type="checkbox"/> (c) <input type="checkbox"/> (d) <input type="checkbox"/> (e) <input type="checkbox"/> (f) <input type="checkbox"/> (g) <input type="checkbox"/> (h) <input type="checkbox"/> (i) <input type="checkbox"/> (j) <input type="checkbox"/> (k) <input type="checkbox"/> (l) <input type="checkbox"/> (m) <input type="checkbox"/> (n) <input type="checkbox"/> (o) <input type="checkbox"/> (p) <input type="checkbox"/> (q) <input type="checkbox"/> (r) <input type="checkbox"/> (s) <input type="checkbox"/> (t) <input type="checkbox"/> (u) <input type="checkbox"/> (v) <input type="checkbox"/> (w) <input type="checkbox"/> (x) <input type="checkbox"/> (y) <input type="checkbox"/> (z) <input type="checkbox"/> (aa) <input type="checkbox"/> (ab) <input type="checkbox"/> (ac) <input type="checkbox"/> (ad) <input type="checkbox"/> (ae) <input type="checkbox"/> (af) <input type="checkbox"/> (ag) <input type="checkbox"/> (ah) <input type="checkbox"/> (ai) <input type="checkbox"/> (aj) <input type="checkbox"/> (ak) <input type="checkbox"/> (al) <input type="checkbox"/> (am) <input type="checkbox"/> (an) <input type="checkbox"/> (ao) <input type="checkbox"/> (ap) <input type="checkbox"/> (aq) <input type="checkbox"/> (ar) <input type="checkbox"/> (as) <input type="checkbox"/> (at) <input type="checkbox"/> (au) <input type="checkbox"/> (av) <input type="checkbox"/> (aw) <input type="checkbox"/> (ax) <input type="checkbox"/> (ay) <input type="checkbox"/> (az) <input type="checkbox"/> (ba) <input type="checkbox"/> (bb) <input type="checkbox"/> (bc) <input type="checkbox"/> (bd) <input type="checkbox"/> (be) <input type="checkbox"/> (bf) <input type="checkbox"/> (bg) <input type="checkbox"/> (bh) <input type="checkbox"/> (bi) <input type="checkbox"/> (bj) <input type="checkbox"/> (bk) <input type="checkbox"/> (bl) <input type="checkbox"/> (bm) <input type="checkbox"/> (bn) <input type="checkbox"/> (bo) <input type="checkbox"/> (bp) <input type="checkbox"/> (bq) <input type="checkbox"/> (br) <input type="checkbox"/> (bs) <input type="checkbox"/> (bt) <input type="checkbox"/> (bu) <input type="checkbox"/> (bv) <input type="checkbox"/> (bw) <input type="checkbox"/> (bx) <input type="checkbox"/> (by) <input type="checkbox"/> (bz) <input type="checkbox"/> (ca) <input type="checkbox"/> (cb) <input type="checkbox"/> (cc) <input type="checkbox"/> (cd) <input type="checkbox"/> (ce) <input type="checkbox"/> (cf) <input type="checkbox"/> (cg) <input type="checkbox"/> (ch) <input type="checkbox"/> (ci) <input type="checkbox"/> (cj) <input type="checkbox"/> (ck) <input type="checkbox"/> (cl) <input type="checkbox"/> (cm) <input type="checkbox"/> (cn) <input type="checkbox"/> (co) <input type="checkbox"/> (cp) <input type="checkbox"/> (cq) <input type="checkbox"/> (cr) <input type="checkbox"/> (cs) <input type="checkbox"/> (ct) <input type="checkbox"/> (cu) <input type="checkbox"/> (cv) <input type="checkbox"/> (cw) <input type="checkbox"/> (cx) <input type="checkbox"/> (cy) <input type="checkbox"/> (cz) <input type="checkbox"/> (da) <input type="checkbox"/> (db) <input type="checkbox"/> (dc) <input type="checkbox"/> (dd) <input type="checkbox"/> (de) <input type="checkbox"/> (df) <input type="checkbox"/> (dg) <input type="checkbox"/> (dh) <input type="checkbox"/> (di) <input type="checkbox"/> (dj) <input type="checkbox"/> (dk) <input type="checkbox"/> (dl) <input type="checkbox"/> (dm) <input type="checkbox"/> (dn) <input type="checkbox"/> (do) <input type="checkbox"/> (dp) <input type="checkbox"/> (dq) <input type="checkbox"/> (dr) <input type="checkbox"/> (ds) <input type="checkbox"/> (dt) <input type="checkbox"/> (du) <input type="checkbox"/> (dv) <input type="checkbox"/> (dw) <input type="checkbox"/> (dx) <input type="checkbox"/> (dy) <input type="checkbox"/> (dz) <input type="checkbox"/> (ea) <input type="checkbox"/> (eb) <input type="checkbox"/> (ec) <input type="checkbox"/> (ed) <input type="checkbox"/> (ee) <input type="checkbox"/> (ef) <input type="checkbox"/> (eg) <input type="checkbox"/> (eh) <input type="checkbox"/> (ei) <input type="checkbox"/> (ej) <input type="checkbox"/> (ek) <input type="checkbox"/> (el) <input type="checkbox"/> (em) <input type="checkbox"/> (en) <input type="checkbox"/> (eo) <input type="checkbox"/> (ep) <input type="checkbox"/> (eq) <input type="checkbox"/> (er) <input type="checkbox"/> (es) <input type="checkbox"/> (et) <input type="checkbox"/> (eu) <input type="checkbox"/> (ev) <input type="checkbox"/> (ew) <input type="checkbox"/> (ex) <input type="checkbox"/> (ey) <input type="checkbox"/> (ez) <input type="checkbox"/> (fa) <input type="checkbox"/> (fb) <input type="checkbox"/> (fc) <input type="checkbox"/> (fd) <input type="checkbox"/> (fe) <input type="checkbox"/> (ff) <input type="checkbox"/> (fg) <input type="checkbox"/> (fh) <input type="checkbox"/> (fi) <input type="checkbox"/> (fj) <input type="checkbox"/> (fk) <input type="checkbox"/> (fl) <input type="checkbox"/> (fm) <input type="checkbox"/> (fn) <input type="checkbox"/> (fo) <input type="checkbox"/> (fp) <input type="checkbox"/> (fq) <input type="checkbox"/> (fr) <input type="checkbox"/> (fs) <input type="checkbox"/> (ft) <input type="checkbox"/> (fu) <input type="checkbox"/> (fv) <input type="checkbox"/> (fw) <input type="checkbox"/> (fx) <input type="checkbox"/> (fy) <input type="checkbox"/> (fz) <input type="checkbox"/> (ga) <input type="checkbox"/> (gb) <input type="checkbox"/> (gc) <input type="checkbox"/> (gd) <input type="checkbox"/> (ge) <input type="checkbox"/> (gf) <input type="checkbox"/> (gg) <input type="checkbox"/> (gh) <input type="checkbox"/> (gi) <input type="checkbox"/> (gj) <input type="checkbox"/> (gk) <input type="checkbox"/> (gl) <input type="checkbox"/> (gm) <input type="checkbox"/> (gn) <input type="checkbox"/> (go) <input type="checkbox"/> (gp) <input type="checkbox"/> (gq) <input type="checkbox"/> (gr) <input type="checkbox"/> (gs) <input type="checkbox"/> (gt) <input type="checkbox"/> (gu) <input type="checkbox"/> (gv) <input type="checkbox"/> (gw) <input type="checkbox"/> (gx) <input type="checkbox"/> (gy) <input type="checkbox"/> (gz) <input type="checkbox"/> (ha) <input type="checkbox"/> (hb) <input type="checkbox"/> (hc) <input type="checkbox"/> (hd) <input type="checkbox"/> (he) <input type="checkbox"/> (hf) <input type="checkbox"/> (hg) <input type="checkbox"/> (hh) <input type="checkbox"/> (hi) <input type="checkbox"/> (hj) <input type="checkbox"/> (hk) <input type="checkbox"/> (hl) <input type="checkbox"/> (hm) <input type="checkbox"/> (hn) <input type="checkbox"/> (ho) <input type="checkbox"/> (hp) <input type="checkbox"/> (hq) <input type="checkbox"/> (hr) <input type="checkbox"/> (hs) <input type="checkbox"/> (ht) <input type="checkbox"/> (hu) <input type="checkbox"/> (hv) <input type="checkbox"/> (hw) <input type="checkbox"/> (hx) <input type="checkbox"/> (hy) <input type="checkbox"/> (hz) <input type="checkbox"/> (ia) <input type="checkbox"/> (ib) <input type="checkbox"/> (ic) <input type="checkbox"/> (id) <input type="checkbox"/> (ie) <input type="checkbox"/> (if) <input type="checkbox"/> (ig) <input type="checkbox"/> (ih) <input type="checkbox"/> (ii) <input type="checkbox"/> (ij) <input type="checkbox"/> (ik) <input type="checkbox"/> (il) <input type="checkbox"/> (im) <input type="checkbox"/> (in) <input type="checkbox"/> (io) <input type="checkbox"/> (ip) <input type="checkbox"/> (iq) <input type="checkbox"/> (ir) <input type="checkbox"/> (is) <input type="checkbox"/> (it) <input type="checkbox"/> (iu) <input type="checkbox"/> (iv) <input type="checkbox"/> (iw) <input type="checkbox"/> (ix) <input type="checkbox"/> (iy) <input type="checkbox"/> (iz) <input type="checkbox"/> (ja) <input type="checkbox"/> (jb) <input type="checkbox"/> (jc) <input type="checkbox"/> (jd) <input type="checkbox"/> (je) <input type="checkbox"/> (jf) <input type="checkbox"/> (jg) <input type="checkbox"/> (jh) <input type="checkbox"/> (ji) <input type="checkbox"/> (jj) <input type="checkbox"/> (jk) <input type="checkbox"/> (jl) <input type="checkbox"/> (jm) <input type="checkbox"/> (jn) <input type="checkbox"/> (jo) <input type="checkbox"/> (jp) <input type="checkbox"/> (jq) <input type="checkbox"/> (jr) <input type="checkbox"/> (js) <input type="checkbox"/> (jt) <input type="checkbox"/> (ju) <input type="checkbox"/> (jv) <input type="checkbox"/> (jw) <input type="checkbox"/> (jx) <input type="checkbox"/> (jy) <input type="checkbox"/> (jz) <input type="checkbox"/> (ka) <input type="checkbox"/> (kb) <input type="checkbox"/> (kc) <input type="checkbox"/> (kd) <input type="checkbox"/> (ke) <input type="checkbox"/> (kf) <input type="checkbox"/> (kg) <input type="checkbox"/> (kh) <input type="checkbox"/> (ki) <input type="checkbox"/> (kj) <input type="checkbox"/> (kk) <input type="checkbox"/> (kl) <input type="checkbox"/> (km) <input type="checkbox"/> (kn) <input type="checkbox"/> (ko) <input type="checkbox"/> (kp) <input type="checkbox"/> (kq) <input type="checkbox"/> (kr) <input type="checkbox"/> (ks) <input type="checkbox"/> (kt) <input type="checkbox"/> (ku) <input type="checkbox"/> (kv) <input type="checkbox"/> (kw) <input type="checkbox"/> (kx) <input type="checkbox"/> (ky) <input type="checkbox"/> (kz) <input type="checkbox"/> (la) <input type="checkbox"/> (lb) <input type="checkbox"/> (lc) <input type="checkbox"/> (ld) <input type="checkbox"/> (le) <input type="checkbox"/> (lf) <input type="checkbox"/> (lg) <input type="checkbox"/> (lh) <input type="checkbox"/> (li) <input type="checkbox"/> (lj) <input type="checkbox"/> (lk) <input type="checkbox"/> (ll) <input type="checkbox"/> (lm) <input type="checkbox"/> (ln) <input type="checkbox"/> (lo) <input type="checkbox"/> (lp) <input type="checkbox"/> (lq) <input type="checkbox"/> (lr) <input type="checkbox"/> (ls) <input type="checkbox"/> (lt) <input type="checkbox"/> (lu) <input type="checkbox"/> (lv) <input type="checkbox"/> (lw) <input type="checkbox"/> (lx) <input type="checkbox"/> (ly) <input type="checkbox"/> (lz) <input type="checkbox"/> (ma) <input type="checkbox"/> (mb) <input type="checkbox"/> (mc) <input type="checkbox"/> (md) <input type="checkbox"/> (me) <input type="checkbox"/> (mf) <input type="checkbox"/> (mg) <input type="checkbox"/> (mh) <input type="checkbox"/> (mi) <input type="checkbox"/> (mj) <input type="checkbox"/> (mk) <input type="checkbox"/> (ml) <input type="checkbox"/> (mn) <input type="checkbox"/> (mo) <input type="checkbox"/> (mp) <input type="checkbox"/> (mq) <input type="checkbox"/> (mr) <input type="checkbox"/> (ms) <input type="checkbox"/> (mt) <input type="checkbox"/> (mu) <input type="checkbox"/> (mv) <input type="checkbox"/> (mw) <input type="checkbox"/> (mx) <input type="checkbox"/> (my) <input type="checkbox"/> (mz) <input type="checkbox"/> (na) <input type="checkbox"/> (nb) <input type="checkbox"/> (nc) <input type="checkbox"/> (nd) <input type="checkbox"/> (ne) <input type="checkbox"/> (nf) <input type="checkbox"/> (ng) <input type="checkbox"/> (nh) <input type="checkbox"/> (ni) <input type="checkbox"/> (nj) <input type="checkbox"/> (nk) <input type="checkbox"/> (nl) <input type="checkbox"/> (nm) <input type="checkbox"/> (nn) <input type="checkbox"/> (no) <input type="checkbox"/> (np) <input type="checkbox"/> (nq) <input type="checkbox"/> (nr) <input type="checkbox"/> (ns) <input type="checkbox"/> (nt) <input type="checkbox"/> (nu) <input type="checkbox"/> (nv) <input type="checkbox"/> (nw) <input type="checkbox"/> (nx) <input type="checkbox"/> (ny) <input type="checkbox"/> (nz) <input type="checkbox"/> (oa) <input type="checkbox"/> (ob) <input type="checkbox"/> (oc) <input type="checkbox"/> (od) <input type="checkbox"/> (oe) <input type="checkbox"/> (of) <input type="checkbox"/> (og) <input type="checkbox"/> (oh) <input type="checkbox"/> (oi) <input type="checkbox"/> (oj) <input type="checkbox"/> (ok) <input type="checkbox"/> (ol) <input type="checkbox"/> (om) <input type="checkbox"/> (on) <input type="checkbox"/> (oo) <input type="checkbox"/> (op) <input type="checkbox"/> (oq) <input type="checkbox"/> (or) <input type="checkbox"/> (os) <input type="checkbox"/> (ot) <input type="checkbox"/> (ou) <input type="checkbox"/> (ov) <input type="checkbox"/> (ow) <input type="checkbox"/> (ox) <input type="checkbox"/> (oy) <input type="checkbox"/> (oz) <input type="checkbox"/> (pa) <input type="checkbox"/> (pb) <input type="checkbox"/> (pc) <input type="checkbox"/> (pd) <input type="checkbox"/> (pe) <input type="checkbox"/> (pf) <input type="checkbox"/> (pg) <input type="checkbox"/> (ph) <input type="checkbox"/> (pi) <input type="checkbox"/> (pj) <input type="checkbox"/> (pk) <input type="checkbox"/> (pl) <input type="checkbox"/> (pm) <input type="checkbox"/> (pn) <input type="checkbox"/> (po) <input type="checkbox"/> (pp) <input type="checkbox"/> (pq) <input type="checkbox"/> (pr) <input type="checkbox"/> (ps) <input type="checkbox"/> (pt) <input type="checkbox"/> (pu) <input type="checkbox"/> (pv) <input type="checkbox"/> (pw) <input type="checkbox"/> (px) <input type="checkbox"/> (py) <input type="checkbox"/> (pz) <input type="checkbox"/> (qa) <input type="checkbox"/> (qb) <input type="checkbox"/> (qc) <input type="checkbox"/> (qd) <input type="checkbox"/> (qe) <input type="checkbox"/> (qf) <input type="checkbox"/> (qg) <input type="checkbox"/> (qh) <input type="checkbox"/> (qi) <input type="checkbox"/> (qj) <input type="checkbox"/> (qk) <input type="checkbox"/> (ql) <input type="checkbox"/> (qm) <input type="checkbox"/> (qn) <input type="checkbox"/> (qo) <input type="checkbox"/> (qp) <input type="checkbox"/> (qq) <input type="checkbox"/> (qr) <input type="checkbox"/> (qs) <input type="checkbox"/> (qt) <input type="checkbox"/> (qu) <input type="checkbox"/> (qv) <input type="checkbox"/> (qw) <input type="checkbox"/> (qx) <input type="checkbox"/> (qy) <input type="checkbox"/> (qz) <input type="checkbox"/> (ra) <input type="checkbox"/> (rb) <input type="checkbox"/> (rc) <input type="checkbox"/> (rd) <input type="checkbox"/> (re) <input type="checkbox"/> (rf) <input type="checkbox"/> (rg) <input type="checkbox"/> (rh) <input type="checkbox"/> (ri) <input type="checkbox"/> (rj) <input type="checkbox"/> (rk) <input type="checkbox"/> (rl) <input type="checkbox"/> (rm) <input type="checkbox"/> (rn) <input type="checkbox"/> (ro) <input type="checkbox"/> (rp) <input type="checkbox"/> (rq) <input type="checkbox"/> (rr) <input type="checkbox"/> (rs) <input type="checkbox"/> (rt) <input type="checkbox"/> (ru) <input type="checkbox"/> (rv) <input type="checkbox"/> (rw) <input type="checkbox"/> (rx) <input type="checkbox"/> (ry) <input type="checkbox"/> (rz) <input type="checkbox"/> (sa) <input type="checkbox"/> (sb) <input type="checkbox"/> (sc) <input type="checkbox"/> (sd) <input type="checkbox"/> (se) <input type="checkbox"/> (sf) <input type="checkbox"/> (sg) <input type="checkbox"/> (sh) <input type="checkbox"/> (si) <input type="checkbox"/> (sj) <input type="checkbox"/> (sk) <input type="checkbox"/> (sl) <input type="checkbox"/> (sm) <input type="checkbox"/> (sn) <input type="checkbox"/> (so) <input type="checkbox"/> (sp) <input type="checkbox"/> (sq) <input type="checkbox"/> (sr) <input type="checkbox"/> (ss) <input type="checkbox"/> (st) <input type="checkbox"/> (su) <input type="checkbox"/> (sv) <input type="checkbox"/> (sw) <input type="checkbox"/> (sx) <input type="checkbox"/> (sy) <input type="checkbox"/> (sz) <input type="checkbox"/> (ta) <input type="checkbox"/> (tb) <input type="checkbox"/> (tc) <input type="checkbox"/> (td) <input type="checkbox"/> (te) <input type="checkbox"/> (tf) <input type="checkbox"/> (tg) <input type="checkbox"/> (th) <input type="checkbox"/> (ti) <input type="checkbox"/> (tj) <input type="checkbox"/> (tk) <input type="checkbox"/> (tl) <input type="checkbox"/> (tm) <input type="checkbox"/> (tn) <input type="checkbox"/> (to) <input type="checkbox"/> (tp) <input type="checkbox"/> (tq) <input type="checkbox"/> (tr) <input type="checkbox"/> (ts) <input type="checkbox"/> (tt) <input type="checkbox"/> (tu) <input type="checkbox"/> (tv) <input type="checkbox"/> (tw) <input type="checkbox"/> (tx) <input type="checkbox"/> (ty) <input type="checkbox"/> (tz) <input type="checkbox"/> (ua) <input type="checkbox"/> (ub) <input type="checkbox"/> (uc) <input type="checkbox"/> (ud) <input type="checkbox"/> (ue) <input type="checkbox"/> (uf) <input type="checkbox"/> (ug) <input type="checkbox"/> (uh) <input type="checkbox"/> (ui) <input type="checkbox"/> (uj) <input type="checkbox"/> (uk) <input type="checkbox"/> (ul) <input type="checkbox"/> (um) <input type="checkbox"/> (un) <input type="checkbox"/> (uo) <input type="checkbox"/> (up) <input type="checkbox"/> (uq) <input type="checkbox"/> (ur) <input type="checkbox"/> (us) <input type="checkbox"/> (ut) <input type="checkbox"/> (uu) <input type="checkbox"/> (uv) <input type="checkbox"/> (uw) <input type="checkbox"/> (ux) <input type="checkbox"/> (uy) <input type="checkbox"/> (uz) <input type="checkbox"/> (va) <input type="checkbox"/> (vb) <input type="checkbox"/> (vc) <input type="checkbox"/> (vd) <input type="checkbox"/> (ve) <input type="checkbox"/> (vf) <input type="checkbox"/> (vg) <input type="checkbox"/> (vh) <input type="checkbox"/> (vi) <input type="checkbox"/> (vj) <input type="checkbox"/> (vk) <input type="checkbox"/> (vl) <input type="checkbox"/> (vm) <input type="checkbox"/> (vn) <input type="checkbox"/> (vo) <input type="checkbox"/> (vp) <input type="checkbox"/> (vq) <input type="checkbox"/> (vr) <input type="checkbox"/> (vs) <input type="checkbox"/> (vt) <input type="checkbox"/> (vu) <input type="checkbox"/> (vv) <input type="checkbox"/> (vw) <input type="checkbox"/> (vx) <input type="checkbox"/> (vy) <input type="checkbox"/> (vz) <input type="checkbox"/> (wa) <input type="checkbox"/> (wb) <input type="checkbox"/> (wc) <input type="checkbox"/> (wd) <input type="checkbox"/> (we) <input type="checkbox"/> (wf) <input type="checkbox"/> (wg) <input type="checkbox"/> (wh) <input type="checkbox"/> (wi) <input type="checkbox"/> (wj) <input type="checkbox"/> (wk) <input type="checkbox"/> (wl) <input type="checkbox"/> (wm) <input type="checkbox"/> (wn) <input type="checkbox"/> (wo) <input type="checkbox"/> (wp) <input type="checkbox"/> (wq) <input type="checkbox"/> (wr) <input type="checkbox"/> (ws) <input type="checkbox"/> (wt) <input type="checkbox"/> (wu) <input type="checkbox"/> (wv) <input type="checkbox"/> (ww) <input type="checkbox"/> (wx) <input type="checkbox"/> (wy) <input type="checkbox"/> (wz) <input type="checkbox"/> (xa) <input type="checkbox"/> (xb) <input type="checkbox"/> (xc) <input type="checkbox"/> (xd) <input type="checkbox"/> (xe) <input type="checkbox"/> (xf) <input type="checkbox"/> (xg) <input type="checkbox"/> (xh) <input type="checkbox"/> (xi) <input type="checkbox"/> (xj) <input type="checkbox"/> (xk) <input type="checkbox"/> (xl) <input type="checkbox"/> (xm) <input type="checkbox"/> (xn) <input type="checkbox"/> (xo) <input type="checkbox"/> (xp) <input type="checkbox"/> (xq) <input type="checkbox"/> (xr) <input type="checkbox"/> (xs) <input type="checkbox"/> (xt) <input type="checkbox"/> (xu) <input type="checkbox"/> (xv) <input type="checkbox"/> (xw) <input type="checkbox"/> (xx) <input type="checkbox"/> (xy) <input type="checkbox"/> (xz) <input type="checkbox"/> (ya) <input type="checkbox"/> (yb) <input type="checkbox"/> (yc) <input type="checkbox"/> (yd) <input type="checkbox"/> (ye) <input type="checkbox"/> (yf) <input type="checkbox"/> (yg) <input type="checkbox"/> (yh) <input type="checkbox"/> (yi) <input type="checkbox"/> (yj) <input type="checkbox"/> (yk) <input type="checkbox"/> (yl) <input type="checkbox"/> (ym) <input type="checkbox"/> (yn) <input type="checkbox"/> (yo) <input type="checkbox"/> (yp) <input type="checkbox"/> (yq) <input type="checkbox"/> (yr) <input type="checkbox"/> (ys) <input type="checkbox"/> (yt) <input type="checkbox"/> (yu) <input type="checkbox"/> (yv) <input type="checkbox"/> (yw) <input type="checkbox"/> (yx) <input type="checkbox"/> (yy) <input type="checkbox"/> (yz) <input type="checkbox"/> (za) <input type="checkbox"/> (zb) <input type="checkbox"/> (zc) <input type="checkbox"/> (zd) <input type="checkbox"/> (ze) <input type="checkbox"/> (zf) <input type="checkbox"/> (zg) <input type="checkbox"/> (zh) <input type="checkbox"/> (zi) <input type="checkbox"/> (zj) <input type="checkbox"/> (zk) <input type="checkbox"/> (zl) <input type="checkbox"/> (zm) <input type="checkbox"/> (zn) <input type="checkbox"/> (zo) <input type="checkbox"/> (zp) <input type="checkbox"/> (zq) <input type="checkbox"/> (zr) <input type="checkbox"/> (zs) <input type="checkbox"/> (zt) <input type="checkbox"/> (zu) <input type="checkbox"/> (zv) <input type="checkbox"/> (zw) <input type="checkbox"/> (zx) <input type="checkbox"/> (zy) <input type="checkbox"/> (zz) | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
4-24-84 | 23c. NAME OF CEMETERY OR CREMATORY
Westview Mem. Pk. Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Balto.. Md. |
| 24. FUNERAL DIRECTOR
G. Truman Schwab | | 25a. DATE REC'D. BY REGISTRAR
5151 Balto. Nat'l. Pike #21229 | | 25b. REGISTRAR'S SIGNATURE
APR 26 1984 | |

BP



TO: THE SECRETARY OF THE ARMY
FROM: THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]



[Extremely faint and illegible body text, appearing to be a memorandum format with multiple lines of text.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 09139 | | | |
|--|--|--|--|--|--|---|--|---|--|---|--|-----------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR P M | |
| WILLIAM H. JORDAN | | | | | | | | 4-10-84 | | | | 5:00 P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. | | | | IF UNDER 1 YEAR MONTHS DAYS | |
| MALE | | WHITE | | FEBRUARY 27, 1897 | | | | 87 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | MD. | |
| PENNSYLVANIA | | UNITED STATES | | | | | | ANNE ARUNDEL | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| ANNAPOLIS | | ANNE ARUNDEL GENERAL HOSPITAL | | | | MOULDER | | | | STEEL COMPT. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13b. STREET ADDRESS | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 401 HOWARD RD. | | | | 21012 | |
| MARYLAND | | | | ANNE ARUNDEL | | ARNOLD | | | | | | | |
| 4. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | | | |
| UNKNOWN | | | | UNKNOWN | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | | |
| YES | | | | W.W.I | | 196-07-8035 | | | | MADELINE S. JORDAN (SAME AS 13) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerotic Vascular Disease | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Chronic Obstructive Lung Disease | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-19-72, to 4-5-1984, that (I) (we) last saw the deceased alive on 4-5-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | | |
| Donald Hugh Hislop | | | | | | | | | | 4-11-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | | | |
| Donald Hugh Hislop | | | | Robinson Road, Severna Park, Md. 21146 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| BURIAL | | APRIL 13, 1984 | | CROWNVILLE VETERANS COM | | | | CROWNVILLE ANNE ARUNDEL MD. | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | 25a. DATE REGD. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| ROBERT S. BARRANCO | | | | APR 16, 1984 | | | | Julia Davidson-Randall | | | | | |

BP _____

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|---|---------|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| Frank Charles Kalivoda Jr. | | | April 13 1984 | | | 8:55 a.m. | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | 7d. BALTIMORE CITY OR COUNTY OF DEATH | |
| Male | White | Nov. 1, 1952 | 31 YRS. | | | April 13, 1984 | Anne Arundel County, MD. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | | U.S.A. | | | | Anne Arundel County, MD. | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Glen Burnie | | North Arundel Hospital | | Pharmacist | | Drug Fair | | |
| 13a. STATE | | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | |
| Maryland | | | A.A. | Glen Burnie | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 21061 348 Shetland Square | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | |
| Frank C. Kalivoda, Sr. | | | Doris A. Clark | | | No (YES, NO, OR UNKNOWN) | | |
| 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT (Mother) | | | 17. ADDRESS | | |
| 217/62/7735 | | | Mrs. Doris A. Kalivoda | | | 1264 Delmont Severn 21144 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I DEATH WAS CAUSED BY: | | | | | | | | |
| IMMEDIATE CAUSE (a) Combined drug intoxication | | | | | | | | |
| 9805 | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | |
| (c) | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | ingested drugs | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | home | | Glen Burnie, A. A. Co., Md. | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | |
| Dennis F. Smyth, M.D. | | | Assistant | | | 4-13-84 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | 111 Penn Street | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. NAME OF CEMETERY OR CREMATORY | | 23c. LOCATION | | | |
| Burial | | | Glen Haven Mem. Prk | | Glen Burnie A.A. Md. | | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Singleton Funeral Home | | | APR 17 1984 | | | John Davidson-Randall | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSPORT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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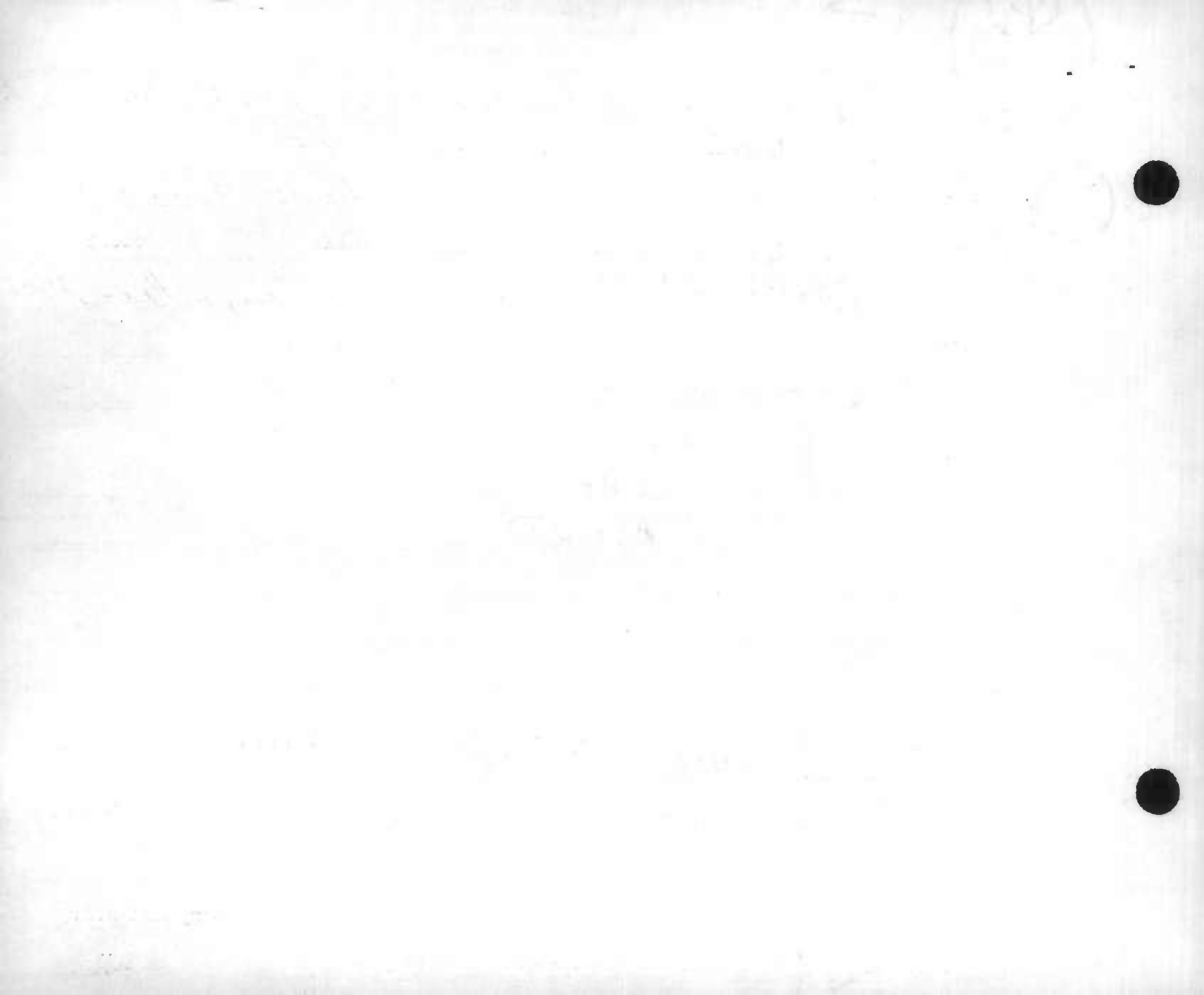


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|---|---|---|--|--------------------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
<i>YETTA C. KANTER</i> | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>4-23-84</i> | | 2b. HOUR
MIN.
<i>4:15 P.M.</i> | |
| 3. SEX
<i>Female</i> | 4. RACE
<i>WHITE</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>Dec. 25 1898</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>85</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Lithuania</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>YES</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>ANNE ARUNDEL</i> MD. | | |
| 10. CITY OR TOWN OF DEATH
<i>ANNAPOLIS, MD.</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>ANNE ARUNDEL General Hospital</i> | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Sales</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>grocery</i> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
<i>13a. MD</i> | | 13b. COUNTY
<i>A.A. Co.</i> | | 13c. CITY
<i>ANNAPOLIS</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Morris Shure</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Bella UNK</i> | | 13e. STREET ADDRESS / ZIP CODE
<i>23 Sampson Place 21401</i> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>NO</i> | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
<i>464-12-7602-21</i> | | 17. INFORMANT
ADDRESS
<i>Bernise Cohn # 13</i> | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
<i>4292</i> IMMEDIATE CAUSE (a) <i>ASPIRATION PNEUMONIA</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>CHF</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>ASCVD</i> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1973</i> , 19____, to <i>4/23/84</i> , 19____, that (I) (same) lost
saw the deceased alive on <i>4/23/84</i> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above; (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>4/23/84</i> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>4-25-84</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Kneseth Israel</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Annapolis, Maryland A.A.</i> |
| 24. FUNERAL DIRECTOR
NAME
<i>T. A. Hardesty</i> | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> |
| ADDRESS
<i>Annapolis Maryland 21401</i> | | | | APR 26 1984 | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09142

1- FOR
STATE
REGISTRAR

REG. NO.

EST

| | | | | | | | | | | |
|--|--|---|--|---|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
NINA E KARY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 6, 1984 | | | 2b. HOUR
330 AM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
October 26, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Severna Park | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
311 Fernwood Dr. 21146 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Felix Walter | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Jane McClain | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
216-05-7473 | | 17. INFORMANT
ADDRESS
L. Jane Brookhart same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4029 IMMEDIATE CAUSE (a) <u>Bronchitis pneumonia, Septic</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>ASCVD; COPD</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Hypertension</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>osteo porosis osteoarthritis</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>87</u> , to <u>4 5</u> 19 <u>88</u> , that (I) (we) last saw the deceased alive on <u>8-5</u> 19 <u>88</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Murriel Paul</u> DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
<u>4 6 88</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MUSTAFA C. OZ, M.D. | | | | | | 22e. ADDRESS
605 BALTIMORE-ANNAPOLIS BOULEVARD
SEVERNA PARK, MARYLAND 21146 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
6 April 84 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Baltimore MD. | | |
| 24. FUNERAL DIRECTOR
NAME
James S. Kirkley Glen Burnie MD. | | | | | | 25. DATE RECEIVED BY REGISTRAR
APR 9 1984 <u>John Davidson-Randall</u> | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked, or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1 - STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|----------------------------------|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Betty Jean Kelley | | | 2a. DATE OF DEATH
MONTH DAY YEAR April 26 1984 | | | 2b. HOUR
MIN. 5⁰⁰ A | | | | | | | | |
| 3. SEX
Female | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR June 5 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS
HOURS MIN. | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Penna | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Annapolis | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
124 Hearne Ct. T1 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Home Maker | | 12b. KIND OF BUSINESS OR INDUSTRY
House Wife | | | | | | |
| 13a. STATE
MARYland | | | 13b. COUNTY
Anne Arundel | | | 13c. CITY OR TOWN
Annapolis | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS
124 Hearne Ct Apt T1 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Arthur wandell | | | 15. MOTHER'S MAIDEN NAME
FIRST
Nell MYERS | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
185 18 1445 | | | 17. INFORMANT
ADDRESS
DEBORAH EVERETT LINTHICUM, MD 21090
417 GROVE RIDGE COURT | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction
4100
DUE TO, OR AS A CONSEQUENCE OF
(b) Hyper Tension
DUE TO, OR AS A CONSEQUENCE OF
(c) 14 year
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from JAN 20 19 84 to APRIL 26 19 84 , that (I) (we) most saw the deceased alive on APRIL 10 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.) | | | | | | | | | | | | | | |
| 22b. SIGNATURE
J.C. Cullis MD | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
April 26, 1984 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
T.C. Cullis | | | | | | 22e. ADDRESS
7111 Ave Severna PARK | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
4/30/84 | | 23c. NAME OF CEMETERY OR CREMATORY
MD. NAT. MEM. PK. | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
LAUREL P.G. MD | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
GEORGE J. GONCE | | | | | | ADDRESS
4001 Ritchie Hwy BALTO MD | | | 25a. DATE REC'D. BY REGISTRAR
APR 30 1984 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
John Davidson | | | | | | | | | | | | | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 09144 | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) BARBARA WICKS KERN | | | | 2a. DATE OF DEATH MONTH DAY YEAR 4-5-84 2b. HOUR M | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 2-28-1970 | | 6. AGE (IN YEARS LAST BIRTHDAY) 14 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A.A. Co. MD. | |
| 10. CITY OR TOWN OF DEATH ARNOLD | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1416 MARINER DR. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY HOME | |
| 13a. STATE MD | | 13b. COUNTY AA | | 13c. CITY OR TOWN ARNOLD | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Wicks | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO 16b. SOCIAL SECURITY NO. — | | | |
| 17. INFORMANT ADDRESS ETHEL HOLTZ - ABOVE | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) carcinoma of bowel DUE TO, OR AS A CONSEQUENCE OF (b) A DUE TO, OR AS A CONSEQUENCE OF (c) — | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Arteriosclerotic atherosclerosis of aorta | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-10 , 19 84 , to 4-5 , 19 84 , that (I) (we) last saw the deceased alive on 2-28 , 19 84 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE G. Smith | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 4-6-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Smith | | 22e. ADDRESS 205 Ridge Ave. Baltimore, MD | | 23a. DATE REC'D. BY REGISTRAR 4-6-84 | | | |
| 23b. BURIAL, CREMATION, REMOVAL BURIAL | | 23c. DATE 4/7/84 | | 23d. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE | | 23e. LOCATION CITY OR TOWN COUNTY STATE DORSEY, HOWARD MD. | |
| 24. FUNERAL DIRECTOR'S NAME Robert S. Lawrence | | ADDRESS Severna Park | | 25a. DATE REC'D. BY REGISTRAR 4-6-84 | | | |
| 24b. REGISTRAR'S SIGNATURE Robert S. Lawrence | | ADDRESS Severna Park | | 25b. REGISTRAR'S SIGNATURE Robert S. Lawrence | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09145

1- FOR
STATE
REGISTRAR

REG. NO.

EST

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
SOON Y ⁱ KIM | | | 2a. DATE OF DEATH MONTH DAY YEAR
APRIL 15, 1984 | | | 2b. HOUR
340 AM | |
| 3. SEX
Female | | 4. RACE
Oriental | | 5. DATE OF BIRTH MONTH DAY YEAR
9 30 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Korea | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13b. STATE 13c. COUNTY 13d. CITY OR TOWN
Maryland A.A. GlenBurnie | | | | | | | |
| 13e. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13f. STREET ADDRESS / ZIP CODE
205 Highland Rd. 21061 | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Soon Gun Park | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Sung Nhu Kim | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
213-92-6541 | | 17. INFORMANT NAME ADDRESS
Hoi Kim 205 Highland Rd. GlenBurnie Md. 21061 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Metastatic Carcinoma of stomach</i>
1519
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
days |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-8</u> , 19 <u>84</u> , to <u>4-15</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>4-15</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Sang C. Doh</i> | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED
<u>4-15-84</u> |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
SANG C. DOH, M.D. | | 22e. ADDRESS
95 AQUAHART ROAD
GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/17/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Prk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge, Howard Md. | |
| 24. FUNERAL DIRECTOR
Raymond C. Fink 426 Crain Hgwy.
GlenBurnie, Md. | | | | 25a. DATE RECD. BY REGISTRAR
APR 16 1984 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<i>John Davidson-Randall</i> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

| | | | | | | | | | |
|---|--|--|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
GEORGE William KLIEVES | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 19, 1984 | | | 2b. HOUR
PM
8.07 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan 31, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
West Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Glass Fact. | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. COUNTY
A.A. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
10 Chester Circle 21061 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Charles Klieves | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
233.01.0909 | | 17. INFORMANT
Step Son | | ADDRESS
301 Baylor Rd. Glen Burnie MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) CARDIOGENIC shock
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) severe congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c) ATHEROSCLEROTIC (ARTERIOSCLEROSIS) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 19 84 to April 19 84 , that (I) (we) last saw the deceased alive on March 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Glenn F. Robbins | | | | | | DEGREE
M.D. | | 22c. DATE SIGNED
Apr 20, 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
GLENN F. ROBBINS | | | | | | 22e. ADDRESS
1404 CRAIN HIGHWAY GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
Apr 23, 84 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie AA MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home, Glen Burnie, MD | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 24 1984 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |

BP

10/19/84 8:07 PM NORTH KILMER GEORGE

10/19/84 8:07 PM NORTH KILMER GEORGE



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10/19/84 8:07 PM NORTH KILMER GEORGE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | EST | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | MONTH DAY YEAR | | MONTH DAY MIN. | |
| GERALD = = KLINE | | | | APRIL 04, 1984 | | 0345 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| MALE | | WHITE | | Feb. 17, 1911 | | 73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | T.V. Repair | | Electronics | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21061 | |
| Maryland A. A. Glen Burnie | | | | | | 423 Crain Highway S.E. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | |
| Henry = Kline | | | | Mary = Ennis | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | | | 212-26-5432 | | Priscilla Kline Same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <i>White Myocardial Infarction</i> | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Coronary Artery Disease</i> | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-6</i> , 19 <i>63</i> , to <i>4-6</i> , 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>4-6</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | 22b. SIGNATURE
<i>Hilary T O'Herlihy</i> | | 22c. DATE SIGNED
<i>4-6-84</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| HILARY T O'HERLIHY M.D. | | | | 325 HOSPITAL DRIVE
GLEN BURNIE MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Entombment | | 4/7/1984 | | Loudon Park Cem. | | Baltimore, = = Maryland | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | 25. DATE REC'D. BY DEPT. OF HEALTH AND MENTAL HYGIENE | | | |
| Raymond C. Fink Glen Burnie, Md. | | | | APR 5 1984 <i>Jana Davidson</i> | | | |

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09148

FOR
1 - STATE
REGISTRAR

REG. NO.

EST

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
BLANCHE R KNEIS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 28, 1984 | | 2b. HOUR
0757 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
5 17 02 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | 12b. KIND OF BUSINESS OR INDUSTRY
Home Maker | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md | | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Abraham Van Meter | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Prell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
214-50-7582 | | 17. INFORMANT
Albert F. Rogall ADDRESS
Baltimore, Md 21226
127 Carvel Beach Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4140 IMMEDIATE CAUSE (a) CHF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) MI
(c) MI
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
Old MI | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
4/17/84 | | 21f. LOCATION
CITY OR TOWN COUNTY STATE
4/28/84 | |
| 22a. I certify that in this hospital I attended the deceased from 4/27/84 to 4/28/84 that (I) (we) last saw the deceased alive on 4/27/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Dr. Jorge B. Ramirez | | DEGREE
M.D. | | 22c. DATE SIGNED
4/29/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JORGE B. RAMIREZ, M.D. | | 22e. ADDRESS
7845 OAKWOOD ROAD, SUITE 205
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
5/1/84 | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md | |
| 24. FUNERAL DIRECTOR
George J. Gonce 4001 Ritchie Hwy Balto, Md | | | | 25a. DATE REC'D. BY REGISTRAR
APR 30 1984 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

W. T. H. 1900

1900

1900

W. T. H. 1900

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W. T. H. 1900

W. T. H. 1900

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09149

1. FOR
STATE
REGISTRAR

REG. NO.

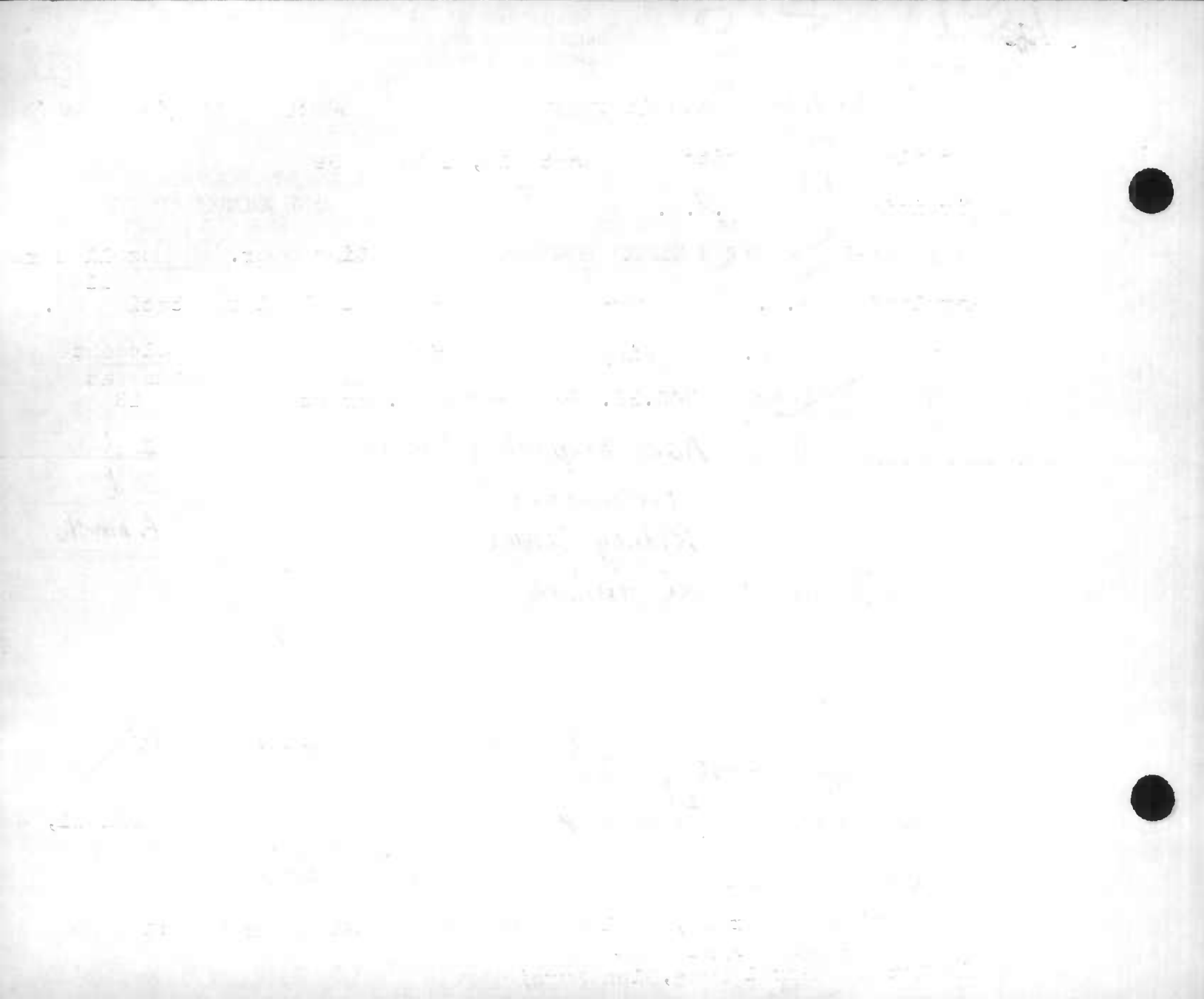
EST

| | | | | | |
|--|---|---|--|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Virginia Claudia KROUT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 11, 1984 | | 2b. HOUR
600 AM |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept 12, 1924 | | 6. AGE (IN YEARS LAST BIRTHDAY)
59 YRS. | 7. UNDER 1 YEAR
MONTHS DAYS
8. UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Line Oper. | 12b. KIND OF BUSINESS OR INDUSTRY
Noxell Corp | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Severn | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
21144
1857 Clark Station Rd. |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Eugene F. King | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lavia Clements | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | 17. INFORMANT
Husband
Vernon A. Krout | ADDRESS
Same as 13
13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u>
1890
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Kidney Cancer</u> | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
2 d
3 d
6 months |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Chronic renal failure</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3-28</u> 19 <u>84</u> to <u>4-11</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>4-10</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Long S. Hsu</u> | | DEGREE
M.D. | | 22c. DATE SIGNED
April 11, 84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LONG S. HSU, M.D. | | 22e. ADDRESS
7845 OAKWOOD ROAD, SUITE 104
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | 23b. DATE
Apr 14, 84 | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie AA MD | |
| 24. FUNERAL DIRECTOR
NAME
<u>Singleton Funeral Home</u> | | 25a. DATE REC'D. BY REGISTRAR
APR 12 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 2 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.



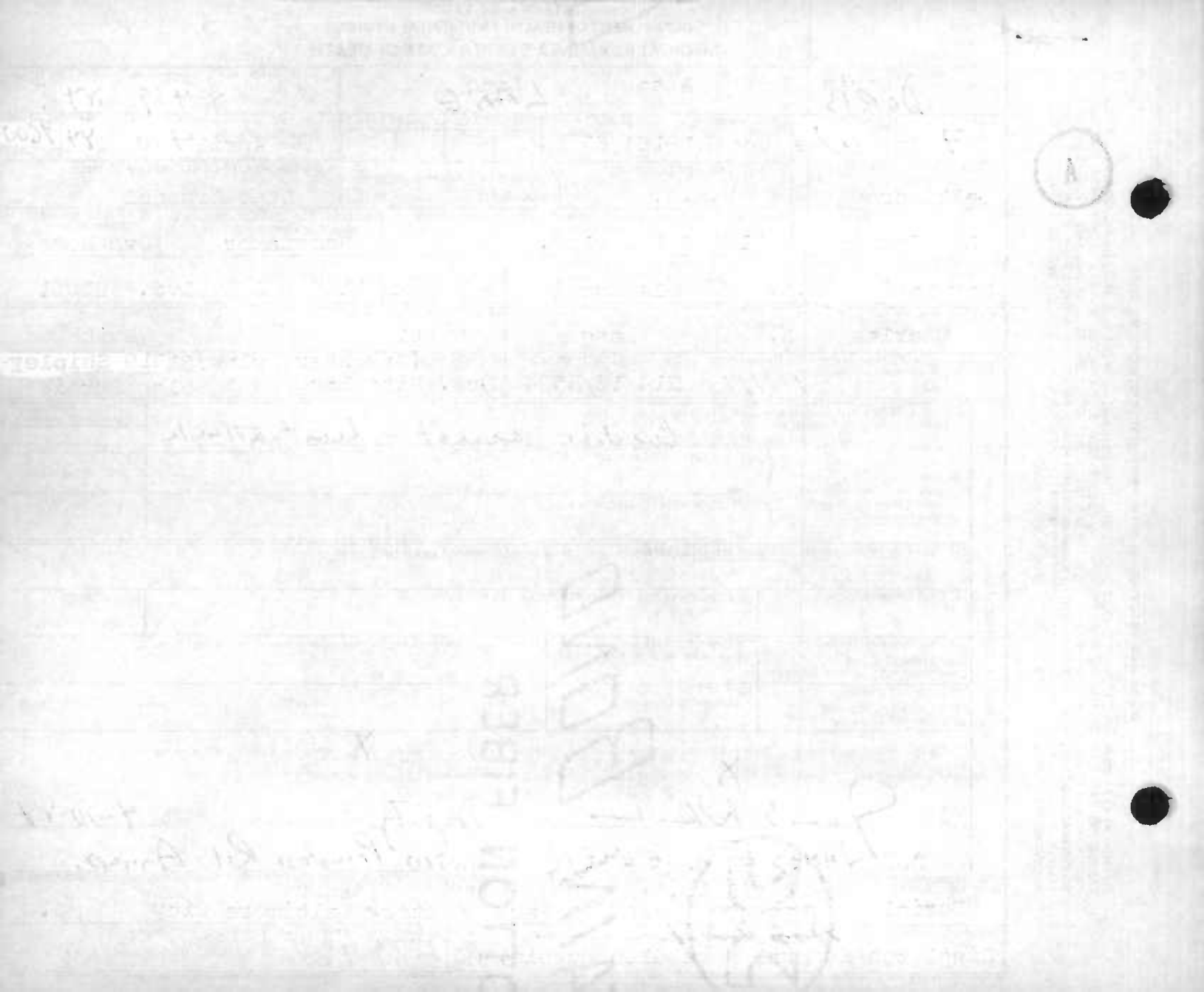
FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

| | | | | |
|--|----------------------|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Doris Anna Lang | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input checked="" type="checkbox"/> DAY <input checked="" type="checkbox"/> YEAR April 9, 84 | | 2b. HOUR 4:00 |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH
MONTH DAY YEAR May 6, 1916 | 6. AGE (IN YEARS)
(LAST BIRTHDAY) 67 YRS. | IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7166 B & A Blvd. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker |
| 13a. STATE Maryland | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Glen Burnie |
| 14. FATHER'S NAME
FIRST MIDDLE LAST Charles A. Lang | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST Myrtle Smith | | 16. SOCIAL SECURITY NO. 214/16/5584 |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214/16/5584 | | 17. INFORMANT (NAME AND ADDRESS) (Daughter In Law) 319 Shipley Ave Glen Burnie |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100 Cardiac arrest - heart attack
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE James E Wheeler | | M.D. Deputy | | DATE SIGNED 4-10-84 |
| EXAMINER'S NAME
(TYPE OR PRINT) JAMES E WHEELER | | ADDRESS 910 Primrose Rd Annap. | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE) Burial | | 23b. DATE April 13, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery |
| 24. FUNERAL DIRECTOR
NAME AB Singleton | | ADDRESS Singleton Funeral Home Glen Burnie, Md | | 25a. DATE REC'D. BY REGISTRAR APR 17 1984 |
| 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 TO FUNERAL DIRECTOR; PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09151

1. FOR
STATE
REGISTRAR

REG. NO.

EST

| | | | | | |
|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
GORDON KENNETH LARRIMORE SR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 4, 1984 | | 2b. HOUR
500 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
10 26 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY
Rices Bakery |
| 13a. STATE
Md | 13b. COUNTY
===== | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS
3735 Tenth Street 21225 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Larrimore | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Viola Gore | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | 16b. SOCIAL SECURITY NO.
215-10-2736 | 17. INFORMANT
ADDRESS
Norma A. Larrimore Same as 13e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u>
<u>1629</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>lung carcinoma</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. certify that (I) (this hospital) attended the deceased from <u>4/7/84</u> 19 <u>84</u> , to <u>4/9/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Fred Kahn</u> | | DEGREE
M.D. | | 22c. DATE SIGNED
4/9/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
FRED T. KAHN, M.D. | | 22e. ADDRESS
7575 RITCHIE HIGHWAY, S.E.
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4/7/84 | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md |
| 24. FUNERAL DIRECTOR
George J. Gonca | | 4001 Ritchie Hgwy Balto | | 25a. DATE REC'D. BY REGISTRAR
APR 9 1984 | 25b. REGISTRAR'S SIGNATURE
<u>Fred Davidson-Randall</u> |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09152

FOR
1. STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM F LEE | | | 2a. DATE OF DEATH
MONTH DAY YEAR 4 15 84 | | 2b. HOUR
1459 M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR Nov 8 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pa. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Sherwood Forest | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
135 Frier Tuck Hill | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Insurance Agt. | | 12b. KIND OF BUSINESS OR INDUSTRY
Life Ins. |
| 13a. STATE
Md | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Sherwood Forest | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Morris M. Lee | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mary Walter | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
WWII 198-07-2904 | | 17. INFORMANT
ADDRESS
Mabel C. Lee #13 | |

| | | |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-RESP. ARREST
1629
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) HYPERCALCEMIA
(c) ADENOCARCINOMA OF THE LUNG | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 MONTH
2 MONTHS |
|---|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:

| | | | | | |
|--|--|--|---|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (this hospital) attended the deceased from JAN 1 , 19 83 , to APR 15 , 19 84 , that (we) lost saw the deceased alive on APRIL 12 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
BARRY R. NATHANSON | | DEGREE
M.D. | | 22c. DATE SIGNED
4/16/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY R. NATHANSON | | 22e. ADDRESS
51 FRANKLIN ST. ANNAP. MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
4/16/84 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitznd P.G. Md. |
| 24. FUNERAL DIRECTOR
NAME
Taylor Funeral Chapel | | ADDRESS
Annapolis Md | | 25a. DATE REC'D. BY REGISTRAR
APR 18 1984 | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner has the authority to examine the body.

21



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | |
|--|---------------------|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
ANDREW Joseph LENTZ | | 2a. DATE KNOWN OF DEATH
MONTH DAY YEAR
4 27 1984 | | 2b. HOUR
0500 |
| 3. SEX
Male | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
5 24 10 | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
73 YRS. | 7. IF UNDER 1 YR.
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH
Pasadena | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8207 Bayside Drive | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Maintenance Mechanic | | 12b. KIND OF BUSINESS OR INDUSTRY
Coast Guard | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Pasadena | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Joseph Lentz | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Agnes Nemecek | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
217-01-6363 | | 17. INFORMANT
ADDRESS
Mrs. Antoinette Lentz Same as #13e |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
1519 IMMEDIATE CAUSE (a) Carcinoma of stomach + metastases
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS
UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | |
| ACTUAL SIGNATURE
JAMES E WHEELER | | TITLE (SPECIFY)
Dep. Ty | | DATE SIGNED
4-27-84 |
| EXAMINER'S NAME
(TYPE OR PRINT)
JAMES E WHEELER | | ADDRESS
910 Primrose Rd Annapolis | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
April 30, 1984 | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | |
| 24. FUNERAL DIRECTOR
NAME
McCutty Funeral Home of Pasadena | | 25a. DATE REC'D. BY REGISTRAR
1 - 1984 | | 25b. REGISTRAR'S SIGNATURE
[Signature] |
| 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY
Anne Arundel | | STATE
Md. |

224

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09154

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|---|---|--|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Blanche — List | | | | 2a. DATE OF DEATH MONTH DAY YEAR 4/19/84 | | | | 2b. HOUR 3:45 A.M. | |
| 3. SEX Female | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 07 10 05 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH ANN ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NANCE North Arundel Conv. Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD. | | 13b. COUNTY ANN AR. | | 13c. CITY OR TOWN GLEN BURNIE | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS ZIP CODE 7830 Berth Rd. Pasadena 21222 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST John ——— Bayner | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie ——— Unknown | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 216-34-3466 | | 17. INFORMANT ADDRESS Mr. Ronald List, Same as above | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE 3 day
1991
DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARCTION 3 months
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (c) METASTATIC DISEASE OF 4 month
UNKNOWN PRIMARY
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).
fracture left hip | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
Heavenly Accident | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE Baltimore City Baltimore Maryland | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/18/84 to 4/19/84 , that (I) (we) last saw the deceased alive on 4/18/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Harijit Singh | | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 4/19/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARIJIT SINGH | | | 22e. ADDRESS #8, 16th AVE, BALTIMORE MD. 21225 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE April 23, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Co. Maryland | | |
| 24. FUNERAL DIRECTOR McCutty Funeral Home, 130 E. Fort Ave. Balto. Md. | | | 25a. DATE REC'D. BY REGISTRAR APR 23 1984 | | 25b. REGISTRAR'S SIGNATURE John Harrison | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

(Faint, illegible handwritten text)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 09155 | |
|---|--|---|--|---|--|--|--|--|---------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
AUGUST A. LUDKE | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 9, 1984 | | | 2b. HOUR
12:15 M | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
DECEMBER 9, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY)
88 YRS | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 7b. IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
BALTIMORE, MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
EDGEWATER | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
15 WILLOW SPRING DRIVE | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING YEARS)
CLERK U.S. POSTAL SERVICE | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
MARYLAND | | | | | | 13b. COUNTY
ANNE ARUNDEL CO. | | 13c. CITY OR TOWN
EDGEWATER | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
AUGUST WILLIAM LUDKE | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE
MARGARET HEMMETER | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WWI | | 17. INFORMANT
ADDRESS
FRANCES M. ADWELL DAUGHTER SAME AS | | | | | |
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Arrest.</u>
5188
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Chronic lung disease</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12H | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Brain atrophy</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME STREET FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/23</u> , 19 <u>84</u> , to <u>4/9</u> , 19 <u>84</u> , that (I) (we) saw the deceased alive on <u>3/23</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE (TYPE OR PRINT)
Rodney L. Brimhall | | | | DEGREE
M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/9/84 | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | | | 23b. DATE
4-10-84 | | 23c. NAME OF CEMETERY OR CREMATORY
METROPOLITAN CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ALEXANDRIA FAIRFAX CO. | | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT E. EVANS ANNAPOLIS, MARYLAND | | | | | | 25a. DATE REC'D. BY STATE HEALTH DEPT.
APR 11 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia L. ... | | | |



[Handwritten signature] APR 11 1894

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09150

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|---|---------------------------|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Agnes M Malkie | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 4, 1984 | | 2b. HOUR
1 P.M. |
| 3. SEX
Female | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
1 21 1902 | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WASH. D.C. | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co., MD. | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | 12a. USUAL OCCUPATION
(LIST OF WORK FOR MOST OF WORKING LIFE)
TELETYPE | 12b. KIND OF BUSINESS OR INDUSTRY
BANK | |
| 13a. STATE
MD. | | 13b. COUNTY
AA | 13c. CITY OR TOWN
Annapolis | 13d. STREET ADDRESS / ZIP CODE
1630 AMERICANA Dr. 21403 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
JOHN A. BREEN | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
MARGARET DRONEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
577-18-7874 | | 17. INFORMANT
Donald J. Malkie ADDRESS
103 BEAR CREEK PKY
EDGEWATER MD. 21037 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4029

IMMEDIATE CAUSE (a) **Hypertensive cerebrovascular disease**

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

15 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

MEDICAL CERTIFICATION

| | | | |
|---|--|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/13 , 19 69 , to 4/4 , 19 84 , that (I) (we) last saw the deceased alive on 3/28 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
John Hedeman MD | DEGREE
MD | | 22c. DATE SIGNED
4/5/84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JOHN HEDEMAN | | 22e. ADDRESS
1407 FOREST DR. ANNAPOLIS MD. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
4/7/84 | 23c. NAME OF CEMETERY OR CREMATORY
Hillcrest | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ANNAPOLIS AA MD. |
| 24. FUNERAL DIRECTOR
NAME
TAYLOR FUNERAL CHAPEL | | 25a. DATE REC'D. BY REGISTRAR
APR 11 1984 | |

BP



BP

DHMH-16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. | | EST | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) AMELIA MAURER | | | | 2a. DATE OF DEATH
MONTH APRIL DAY 08 YEAR 1984 | | 2b. HOUR
0815 PM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH September DAY 6 YEAR 1909 | | 6. AGE (IN YEARS LAST BIRTHDAY)
74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FORM OR WORKING LIFE)
Retired Clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Life Insurance | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Pasadena | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13. STREET ADDRESS
205 Bar Harbor Road 21122 | |
| 14. FATHER'S NAME
FIRST Edward MIDDLE LAST Himmeler | | | | 15. MOTHER'S MAIDEN NAME
FIRST Henrietta MIDDLE LAST Homborg | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
214-12-8117 | | 17. INFORMANT
ADDRESS 24 N. Beechwood Avenue Catonsville, Md. 21228
Daniel G. Werner, M.D. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) cardiac arrest
4275
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 23a. SIGNATURE
Marc A Kaplan | | | | DEGREE | | 23b. DATE SIGNED
4/9/84 | |
| 23c. PHYSICIAN'S NAME (TYPE OR PRINT)
MARC A KAPLAN, M.D. | | | | 23d. ADDRESS
7845 OAKWOOD ROAD, SUITE 200
GLEN BURNIE, MARYLAND, 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4/12/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Oak Lawn Cemetery | | 23d. LOCATION
CITY OR TOWN Baltimore COUNTY Maryland STATE | |
| 24. FUNERAL DIRECTOR
McCutty Funeral Home of Pasadena
Mountain and Tick Neck Roads, Pasadena, Maryland | | | | 25. DATE REC'D. BY REGISTRAR
APR 12 1984 | | | |
| | | | | 26. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or a post-mortem examination requested.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09158

REG. NO.

| | | | | | | | | | |
|--|--|--|--|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CHARLES WALTER MC KEAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 22, 1984 | | | 2b. HOUR
M
M | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
FEV. 23, 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY)
73 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PENNSY. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEE MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8000 Nolcrest Road | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Moldmaker (ret.) | | 12b. KIND OF BUSINESS OR INDUSTRY
Glass Co. | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | | 13b. COUNTY
A.A.Co. | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
(unknown) MC KEAN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
(unknown) | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
NO | | | |
| 16b. SOCIAL SECURITY NO.
212.10.6210 | | | 17. INFORMANT (niece)
BARBARA A. RIGGIN | | | ADDRESS
SAME AS #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) Cancer of the lung.
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Apr. 23, 1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHARLES J. WU, M.D. | | | 22e. ADDRESS
7845 OAKWOOD ROAD
GLEN BURNIE, MD. 21061 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
Apr 25/84 | | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE, MD. | | |
| 24. FUNERAL DIRECTOR
SINGLETON FUNERAL HOME | | | ADDRESS
GLEN BURNIE, MD. | | | 25a. DATE REC'D. BY REGISTRAR
APR 27 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | | | | | | | | |

BP

RECEIVED

APR 22 1964

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

2025

100

MAIL ROOM

100

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U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

2025

MAIL ROOM

U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

2025

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U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

2025

100

[Faint, mostly illegible text in the main body of the document, possibly a letter or report.]

U.S. DEPARTMENT OF AGRICULTURE
WASHINGTON, D.C.

2025

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U.S. DEPARTMENT OF AGRICULTURE

WASHINGTON, D.C.

2025

100

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 9159 | |
|--|--|------------------|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James Frederick Megenhardt Jr. | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR April 4, 1984 | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH (MONTH DAY YEAR) Dec. 3, 1983 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 4 | | 7c. DATE PRONOUNCED DEAD April 4, 1984 | | 2b. HOUR P M 5:27 P M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County Y MD. | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None | | | 12b. KIND OF BUSINESS OR INDUSTRY /// | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS (21061) 7699 Nancy Rd. Apt. 204 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Frederick Megenhardt | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shelby Jean Smith | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | (IF YES, GIVE WAR OR DATES) // | | 16b. SOCIAL SECURITY NO. None | | 17. INFORMANT (Mother) ADDRESS Miss Shelby Smith Same as #13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Stab Wounds
9660
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).
Scalding | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MIN. MONTH DAY YEAR 3:45 P.M. 4/4/84 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject stabbed | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 7699 Nancy Rd., Apt. 204, Glen Burnie, Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>G. R. Kauffman</i> | | | | | | TITLE (SPECIFY) M.D. Assistant | | | MEDICAL EXAMINER | | |
| EXAMINER'S NAME (TYPE OR PRINT) Gregory R. Kauffman, M.D. | | | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | DATE SIGNED 4/5/84 | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE April 7, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn A.A. Md. | |
| 24. FUNERAL DIRECTOR NAME Dean P. Charlton ADDRESS Singleton Funeral Home Glen Burnie, Md | | | | | | | | | | | |
| 25. DATE REC'D BY REGISTRAR APR 6 1984 | | | | | | | | | | | |
| 25a. REGISTRAR'S SIGNATURE <i>John Davidson</i> | | | | | | | | | | | |

RECEIVED
FEBRUARY 19 1964
U.S. AIR FORCE

NO 207

43814-10110

APR 6 1964
U.S. AIR FORCE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-pen. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09160

REG. NO.

EST

| | | | | | | | | | |
|--|--|---|--|---|--|--|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
MARY C. (MARIE) MILLER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 11, 1984 | | | 2b. HOUR
5:10A M | | | |
| 3. SEX
F. | | 4. RACE
W. | | 5. DATE OF BIRTH
MONTH DAY YEAR
10/15/05 | | 6. AGE (IN YEARS LAST BIRTHDAY)
78. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE
(COUNTRY)
Baltimore | | 7b. CITIZEN OF WHAT COUNTRY?
— | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | |
| 13a. STATE
Md. | | 13b. COUNTY
Baltimore | | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS
1371 Pineville Ave. | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Gallagher | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Scheikung | | | | | |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 18. SOCIAL SECURITY NO.
212-34-2923 | | 17. INFORMANT
ADDRESS
Douglas Miller 7985 Olive Pl. East | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
2030 IMMEDIATE CAUSE (a) cardiorespiratory arrest
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Multiple Myeloma
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/13, 1984, to 4/11, 1984, that (I) (we) last saw the deceased alive on 4/10, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Fred Kahn | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/10/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Fred Kahn | | | 22e. ADDRESS
7575 Ritchie Hwy, Glen Burnie Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE)
Burial | | | 23b. DATE
4/14/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Mount Vernon | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Md. | | |
| 24. FUNERAL DIRECTOR
NAME
Charles Stenson | | | 25. DATE REC'D. BY REGISTRAR
APR 13 1984 | | | 26. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

BP

(1049)

100% COLLECTED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and the funeral director, the certificate should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 09161 | |
|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH MONTH DAY YEAR | |
| LILLIAN MAY MITCHELL | | | | APRIL 2, 1984 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | |
| FEMALE | | WHITE | | 04 02 07 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| OHIO | | U.S.A. | | 77 YRS. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| GLEN BURNIE | | NORTH ARUNDEL HOSPITAL | | ANNE ARUNDEL COUNTY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STREET ADDRESS / ZIP CODE | |
| CLERK | | DEPT. STORE | | TOWN & COUNTRY APTS. 21043 | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | |
| MARYLAND | | HOWARD | | ELLICOTT CITY | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | |
| JOHN F. FRUSH | | KATHERINE YOUNG | | NO | |
| 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | |
| 215-07-2555 | | G. ROBERT MITCHELL 21900 RINCONADA ROAD | | 4860 IMMEDIATE CAUSE (a) <u>Acute Respiratory failure</u> | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia, left middle</u> | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) _____ | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Status post Cerebrovascular accident, Urinary tract infection.</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (we) (this hospital) attended the deceased from <u>March 23 1984</u> to <u>April 2 1984</u> , that (we) (we) last saw the deceased alive on <u>April 2 1984</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | 22b. SIGNATURE <u>P. Hung</u> DEGREE _____ | | 22c. DATE SIGNED <u>4/2/84</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | |
| PO-HSLU HUNG, M.D. | | 3450 FT. MEADE ROAD # 207 LAUREL, MARYLAND 20707 | | CREMATION | |
| 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 04-04-84 | | SECURITY PROCESS | | CATONSVILLE BALTIMORE MD. | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. | | 21229 APR 4 1984 | | Julia Davidson-Rendall | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
STATE
REGISTRAR

REG. NO.

EST

| | | | | | | | |
|--|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
RICHARD WILLARD MORGAN, JR. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 17, 1984 | | | 2b. HOUR
1:00 P.M. | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Feb. 20, 1944 | | 6. AGE (IN YEARS LAST BIRTHDAY)
40 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY
Koppers Co. | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
GlenBurnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Richard W. Morgan, Sr. | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Gladys I. Pilkerton | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
216/44/7416 | |
| 17. INFORMANT (Sister)
Mrs. Carol L. Hubers | | 18. ADDRESS
11 Roosevelt Ave.
Glen Burnie | | 19. DATE OF OPERATION | | 20. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 22a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 22b. I certify that (I) (this hospital) attended the deceased from 4/16/84 to 4/17/84, and that (I) (we) lost the deceased alive on 4/17/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If I (we) did not view the body after death, so state.) | | 22c. DATE SIGNED
4/17/84 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Jorge B. Ramirez, M.D. | | 22e. ADDRESS
7845 OAKWOOD ROAD, #205
GLEN BURNIE, MARYLAND 21061 | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE)
Burial | | 23b. DATE
April 20, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem.Pk. ElkrIDGE RFD, Md. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home Glen Burnie, Md | | 25a. DATE REC'D. BY REGISTRAR
APR 19 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | 25c. DATE REC'D. BY REGISTRAR
APR 19 1984 | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

5728

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)

Liver embolism - CVA - G2 Bleeds

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transfer permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

de M.

22/7/14

7/2/8

23/01/14

Mr. J. H. Jones

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72A after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation conducted.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 09163 | |
|--|--|--|--|---|--|--|--|--|--|--|--|
| FOR
STATE
REGISTRAR Emma J MOYER | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Emma J. Moyer | | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 18 84 | | 2b. HOUR
1145 AM | | | |
| 3. SEX
F | | 4. RACE
W | | 5. DATE OF BIRTH
MONTH DAY YEAR
5 18 18 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 7b. IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GEN. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | | | |
| 13a. USUAL RESIDENCE (IF HUSBAND HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE COUNTY
Maryland A.A. | | | | 13b. CITY OR TOWN
Edgewater | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
1430A Oak Bluff Road 21037 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Humphrey May, Sr. | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lucinda Larue | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
218-12-5252 | | 17. INFORMANT ADDRESS
Barbara Kidwell/1430A Oak Bluff Rd/Edgewater Md 21037 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Respiratory Failure</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Obstructive & Restrictive Lung Disease</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic Infection (Tbc) & Cigarette Smoking</u>
0119
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>Acute Lower Resp. Infection</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY BY ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (1) (the hospital) attended the deceased from <u>4-13</u> 19 <u>84</u> , to <u>4-18</u> 19 <u>84</u> , that (b) (we) lost <u>4-17</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (b) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Arnold G. Alexander, MD</u> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
4-18-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>Arnold G. Alexander, MD</u> | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | 23b. DATE
04/20/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Crematorium | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville/Balto Md 21228 | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Walters Funeral Home | | | | ADDRESS
Balto Md 21223
Pratt & Stricker Streets | | 25a. DATE REC'D. BY REGISTRAR
APR 23 1984 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
<u>J. H. Davidson</u> | | | | | | | | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 09164
CERTIFICATE OF DEATH

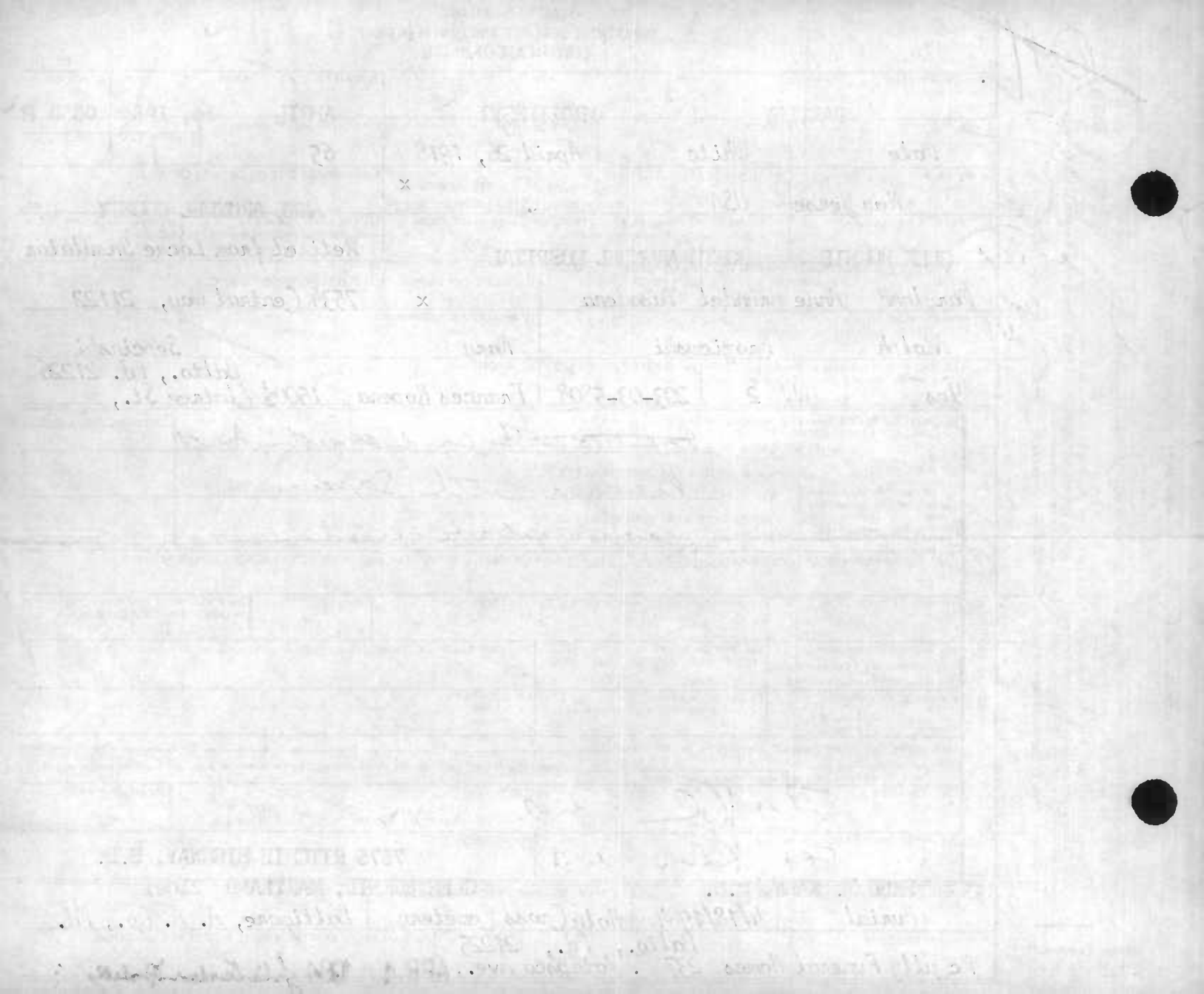
| | | | | | |
|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | EST | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
BARTLEY J PROZIEWSKI | | | 2a. DATE OF DEATH MONTH DAY YEAR
APRIL 14 1984 | | 2b. HOUR
0830 PM |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
April 26, 1918 | |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New Jersey | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 9. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired from Locke Insulator | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Pasadena | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Adolph Mroziowski | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Mary Sepcinski | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
203-03-5808 | | 17. INFORMANT ADDRESS
Frances Kopera 1500 1/2 Elmtree St., Balto., Md. 21226 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia with Cardiovascular Arrest
4360 DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia with Sepsis
DUE TO, OR AS A CONSEQUENCE OF
(c) Cerebrovascular accident
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Fred Kaku | | DEGREE
ATTENDING PHYSICIAN MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Fred Kaku | | 22e. ADDRESS
7575 RITCHIE HIGHWAY, S.E. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/18/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Holy Cross Cemetery | |
| 24. FUNERAL DIRECTOR NAME
McGully Funeral Homes | | 24b. ADDRESS
Balto., Md., 21225
237 E. Patapsco Ave. | | 25a. DATE REC'D. BY REGISTRAR
APR 19 1984 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
John Kevin Randall | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09165

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|---|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) - Violet M. Mumford | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4-10-84 | | | 2b. HOUR
2:14 M | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
10-5-03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
OREGON | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN ABOVE FACILITY, GIVE STREET ADDRESS)
A.A. GEN. Hospt. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
LIBRARIAN | | 12b. KIND OF BUSINESS OR INDUSTRY
Co. Govt. Pst. | |
| 13a. STATE
MD. | | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
ANNAPOLIS | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES A COE | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LILLIE ALLEN | | | 13e. STREET ADDRESS / ZIP CODE
1900 GENERALS Hwy 21401 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
- | | 17. INFORMANT
ADDRESS
EDGAR R. Mumford #13 | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

1830

IMMEDIATE CAUSE (a)

Ovarian carcinoma

APPROXIMATE INTERVAL

BETWEEN ONSET AND DEATH

3 mos.

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> 19 <u>84</u> , to <u>April 9</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>April 9</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>J. Selonice, M.D.</i> | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/10/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stuart E. Selonice, M.D. | | | | 22e. ADDRESS
51 Franklin St. Annapolis, Md. | | | |

| | | | | | | | |
|---|--|-----------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | 23b. DATE
4/13/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Georgetown Vet. Cmt | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Georgetown AA MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Taylor Funeral Chapel Annapolis, Md. | | | | 25a. DATE REC'D. BY REGISTRAR
APR 11 1984 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09166

REG. NO.

EST

| | | | | | |
|--|--|---|---|---|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
JAMES WILLIAM NEUBERT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 27, 1984 | | 2b. HOUR
3:30P M |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan 12, 1917 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | 12b. KIND OF BUSINESS OR INDUSTRY
U.S.C.G. Yard | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Neupert | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Margaret Gray | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W. II 212.09.7196 | | 17. INFORMANT
Wife
ADDRESS
Same as 13
Audrey M. Neubert | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4413 IMMEDIATE CAUSE (a) Ruptured abdominal aortic aneurysm
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Arteriosclerotic heart disease | | | | | |
| 19a. DATE OF OPERATION
4/27/84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Ruptured Aneurysm | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 21. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/27 19 84 , to 4/27 19 84 , that (I) (we) lost
saw the deceased alive on 4/27/84 19 _____, and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Arthur Goodwin M.D. | | 22c. ADDRESS
North Arundel Hospital, Glen Burnie Maryland | | 22d. DATE SIGNED
4/27/84 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)
Arthur Goodwin | | 22f. ADDRESS
North Arundel Hospital, Glen Burnie Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial 1 | | 23b. DATE
May 1, 84 | | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem Pk | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard MD | | 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home, Glen Burnie, MD | | | |
| 25a. DATE REC'D. BY REGISTRAR
MAY 1 - 1984 | | 25b. REGISTRAR'S SIGNATURE
John Gordon-Randall | | | |

BP

BP

DHMM - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | |
| 3. SEX | | | | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| 10. CITY OR TOWN OF DEATH | | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| 13a. STATE | | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Occlusion of distal aorta</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>3 days</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <th colspan="5">APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH </th> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Organic Brain Syndrome</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>4/13/84</u> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>occlusion distal aorta</u> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>4/7/84</u> to <u>4/17/84</u> that (1) (we) last saw the deceased alive on <u>4/7/84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Arthur L. Gudwin, M.D.</u> | | | | | 22c. DATE SIGNED
<u>4/17/84</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |

ARTHUR L. GUDWIN, M.D.
7310 RITCHIE HIGHWAY
GLEN BURNIE, MARYLAND 21061

CREMATION 4/18/1984 GREEN MOUNT CREMATORY BALTIMORE, MARYLAND

WALTER BROOKS BRADLEY, INC. DUNDALK, MD. 21222 APR 18 1984



20% COTTON LITE

CHIEFTAIN



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 09168 | |
|---|---|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. | | EST |
| 1. DECEASED NAME
(TYPE OR PRINT)
JOHN HENRY NIEBERLEIN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 19, 1984 | | 2b. HOUR
10:58 A.M. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
September 5, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(NAME OF WORK OR MOST OF WORKING LIFE)
Tool & Dye Man | | 12b. KIND OF BUSINESS OR INDUSTRY
Martin Marietta |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE Maryland 13a. COUNTY Anne Arundel 13b. CITY OR TOWN Pasadena | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
1423 Woodland Beach Road 21122 | |
| 14. FATHER'S NAME
FIRST George MIDDLE LAST Nieberlein | | 15. MOTHER'S MAIDEN NAME
FIRST Margaret MIDDLE LAST O'Brien | | 16. ADDRESS
Pasadena, Md. 21122 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO.
212-03-4114 | | 17. INFORMANT
Mrs. Emma M. Nieberlein 1423 Woodland Beach | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5860 Cardiac Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (c) Renal Failure | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-17-84 to 4-19-84 that (I) (we) last saw the deceased alive on 4-19-84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Chackumkal V. Cyriac | | DEGREE
M.D. | | 22c. DATE SIGNED
4-19-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
CHACKUMKAL V. CYRIAC, M.D. | | 22e. ADDRESS
14 WELLHAM AVENUE #101
GLEN BURNIE, MARYLAND 21061 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4/23/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie Anne Arundel Md. | | 23e. DATE REC'D. BY REGISTRAR
APR 23 1984 | | | |
| 24. FUNERAL DIRECTOR
Mc Guffy Funeral Home of Pasadena, Md. 21122
Mountain and Flor Neck Roads | | | | | |

20% CO-OP FILE

CHIEF XAM



Handwritten notes and text, mostly illegible due to extreme fading and bleed-through from the reverse side of the page. Some faint words like "CHIEF XAM" and "20% CO-OP FILE" are visible.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09169

1- STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Elizabeth E Offer | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4-18-84 | | 2b. HOUR
7:40 AM |
| 3. SEX
F | 4. RACE
Black | 5. DATE OF BIRTH
MONTH DAY YEAR
10 4 92 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Md. 13b. COUNTY A.A. 13c. CITY OR TOWN Churchton 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
1018 Rogers Rd. 20733 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
LEVI GRAY | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
ROBERTA BURLEY | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
ADDRESS
JACQUILINE FOGG 4849 Shady Side, Md. 20764
Atwell Rd. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

| | | |
|---|--|-------|
| 2765 | IMMEDIATE CAUSE (a) 1) Dehydration | 1 WKs |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | DUE TO, OR AS A CONSEQUENCE OF (b) 2) Atrial Fibrillation | Yrs |
| | DUE TO, OR AS A CONSEQUENCE OF (c) 3) Generalized atherosclerosis | Yrs |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

4) Cerebral infarction & (R) hemiparesis

| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |

22a. I certify that (I) (this hospital) attended the deceased from **3/1/83**, to **4/18/84**, that (I) (we) lost **3/1/83** saw the deceased alive on **3/1/83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

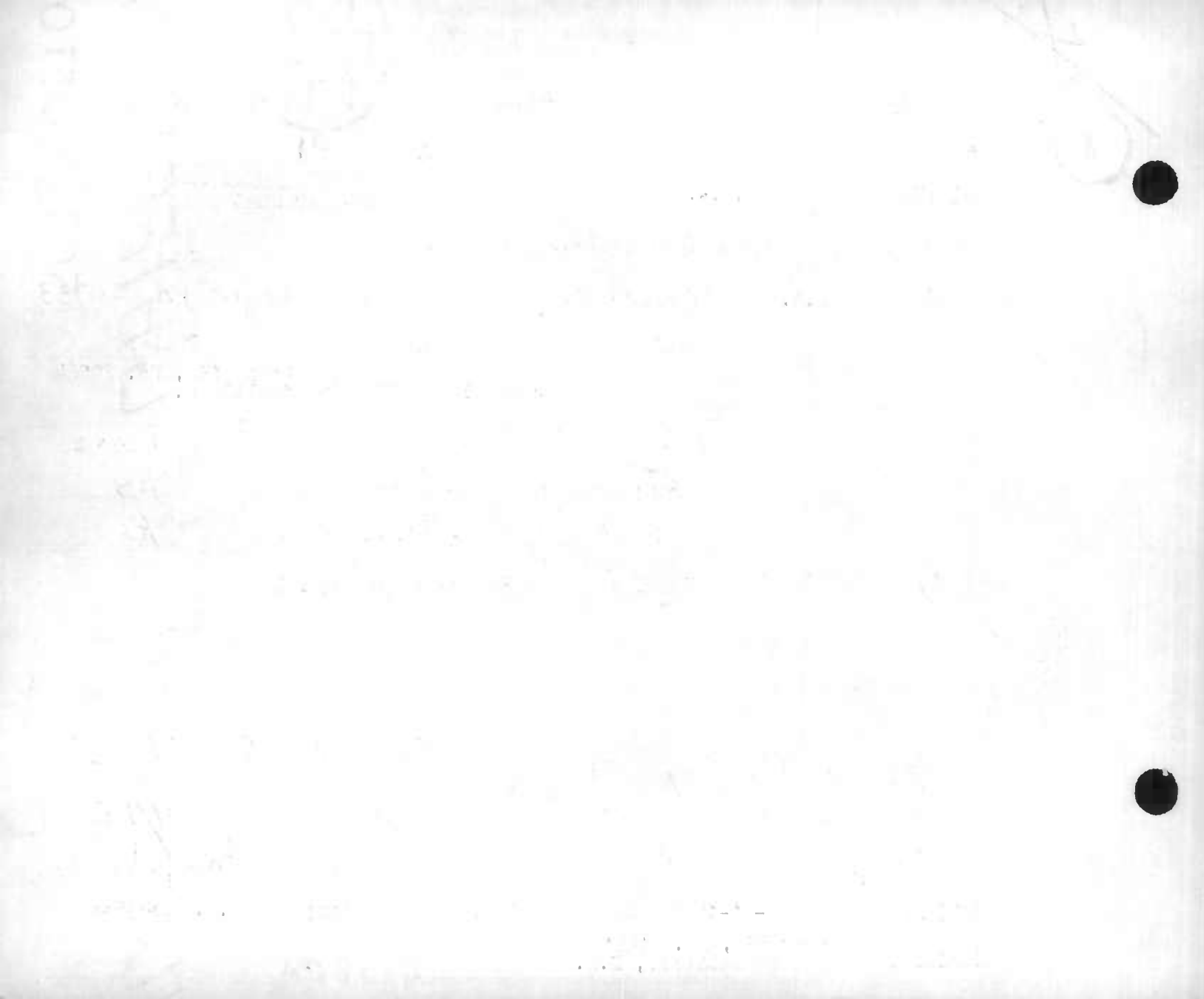
| | | |
|--|--|------------------------------------|
| 22b. SIGNATURE
Joseph N. Friend M.D. | DEGREE | 22c. DATE SIGNED
4/18/84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph N. Friend | 22e. ADDRESS
205 Ridgely Ave. Annapolis, Md. | |

| | | | |
|--|-------------------------------|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
BURIAL | 23b. DATE
4-21-1984 | 23c. NAME OF CEMETERY OR CREMATORY
MOSES CEMETERY | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Drury A.A. Maryland |
| 24. FUNERAL DIRECTOR
WILLIAM REESE & SONS MORTUARY, P.A. | | 25a. DATE REC'D. BY REGISTRAR
APR 19 1984 | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please retain the certificate for 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. Please retain the certificate for 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMM - 16 50M 4/83
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09170

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Stanley M Olson | | | 2a. DATE OF DEATH
MONTH DAY YEAR 04-03-84 | | 2b. HOUR
8:36 P.M. |
| 3. SEX
Male | 4. RACE
W | 5. DATE OF BIRTH
MONTH DAY YEAR
02-03-03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
81 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington, D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Sheet Metal Mech. | 12b. KIND OF BUSINESS OR INDUSTRY
Self-employed | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Deale | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
304 Deale Road 20715 |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Carl Olson | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Georgia Baumbach | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Carl Olson | |
| | | | | ADDRESS
Lothian, MD | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) Metastatic Lung Cancer
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (i) (this hospital) attended the deceased from 3/21/84 to 4/3/84 , that (ii) (we) last saw the deceased alive on 4/3/84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Ensis W. Cole | | DEGREE
MD | | 22c. DATE SIGNED
4/3/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E W COLE | | 22e. ADDRESS
51 FRANKLIN ANNAPOLIS Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
April 6, 1984 | 23c. NAME OF CEMETERY OR CREMATORY
Southern Memorial | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Dunkirk, MD Calvert |
| 24. FUNERAL DIRECTOR
NAME
Rausch Funeral Home | | ADDRESS
Owings, MD | | DATE RECEIVED
APR 9 1984 | |

MEDICAL CERTIFICATION

~~CONFIDENTIAL~~

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|--|--|---|--|---|--|---|--|--------------------------------|--|---|-----|-------|----------|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| ANTHONY | | Orlando | | Orlando | | Orlando | | 4 | | 24 | 84 | 0805 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | | |
| MALE | | CAUCASIAN | | 8 25 83 | | 100 | | MONTHS | | DAYS | | HOURS | |
| 7a. BIRTHPLACE
COUNTRY | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | |
| Italy | | Italy | | | | Anne Arundel | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Annapolis | | 21401 Anne Arundel Co. General Hospital | | Labored | | Transit Co. | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS / ZIP CODE | | | | | |
| Maryland | | - | | Baltimore | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 4526 Parkside Dr. 21206 | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | |
| Unknown | | Unknown | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | | | | |
| | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Right lower lobe pneumonia</u>
4860
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>Sev. weeks</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>Recurrent urinary tract infection - Acute - Cochlear</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | | | | | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4/25</u> 19 <u>84</u> to <u>4/26</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>4/23/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>[Signature]</u> | | DEGREE
<u>MD</u>
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>4/24/84</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | 4/26/84 | | Sacred Heart of Jesus | | Baltimore County, Md | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>Brudzinski Funeral Home PA 1407 Old Eastern Ave</u> | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE
<u>[Signature]</u> | | | | | | | | | |
| | | APR 26 1984 | | | | | | | | | | | |

BP. _____

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09172

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | | | |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Evelyn Frances Padgett | | | 2a. DATE OF DEATH MONTH DAY YEAR
April 6, 1984 | | | 2b. HOUR
A | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
JAN. 2, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
90 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN U.S.A., GIVE STREET ADDRESS)
Chase Home | | 12a. USUAL OCCUPATION
(DATE OF WORK FOR MOST OF WORKING LIFE)
Telephone Operator | | 12b. KIND OF BUSINESS OR INDUSTRY
Balt. | | | |
| 13a. STATE
MD. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
ANNAPOLIS | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
22 Maryland Ave | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Wm Padgett | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
EMMA Bogges | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | | | |
| 16b. SOCIAL SECURITY NO.
213-14-0518 | | 17. INFORMANT
M. Helen Elliott | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4292 | | IMMEDIATE CAUSE (a)
Cardiovascular Accident | | DUE TO, OR AS A CONSEQUENCE OF
(b)
Greg | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Greg | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/22 19 84 to 3/22 19 84 , that (I) (we) saw the deceased alive on 3/22 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Dr. Richard I. Hochman | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/6/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. Richard I. Hochman | | 22e. ADDRESS
16 Murray Ave, Annapolis, MD. 21401 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
CREMATION | | 23b. DATE
4/7/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN STATE
P.G. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Taylor Funeral Chapel Annapolis, MD | | 25a. DATE REC'D. BY REGISTRAR
APR 11 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09173

REG. NO.

| | | | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|---|--|-------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Verna Faye | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 4 1984 | | | 2b. HOUR
3:00P M | | | | | | | |
| 3. SEX
Female | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 27 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 7b. IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Fairview N.C. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Annapolis Convelesent Cent | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
School Teacher | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. STATE
Md. | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
26 Fitzgerald Rd. | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
James Edward Schuford | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Minnie Foster | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
NONE | | | 17. INFORMANT
James Patton | | | ADDRESS
26 Fitzgerald Rd. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>CARDIO RESPIRATORY ARREST,</u>
<u>4019</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>HAIP</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>COPD</u> | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
<u>hypertension, Semile dementia</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>4/1</u> 19 <u>84</u> , to <u>4/4</u> 19 <u>84</u> , that (we) last saw the deceased alive on <u>4/1</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, <u>and did (did not) view the body after death.</u> | | | | | | | | | | | | | |
| 22a. SIGNATURE
<u>Michael J. LaPenta</u> | | | | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>4/4/84</u> | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<u>MICHAEL J. LaPENTA MD</u> | | | | | 22e. ADDRESS
<u>703 GARDINGS AVE ANNAPOLIS MD</u> | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | 23b. DATE
4/5/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Westview Crematory | | | 23d. LOCATION
CITY OR TOWN
Baltimore | | COUNTY
Md. | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
Hardesty Funeral Home | | | | | 12 ADDRESS
Ridgely Ave
Annapolis Md. | | | 25. DATE REC'D. BY REGISTRAR
APR 6 1984 | | 26. REGISTRAR'S SIGNATURE
<u>John Davidson-Randall</u> | | | |

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ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED

DATE 10/10/00 BY 6032

EXCEPT WHERE SHOWN OTHERWISE, THIS DOCUMENT IS IN THE PUBLIC DOMAIN

AND IS NOT TO BE REPRODUCED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE NATIONAL ARCHIVES

DATE 10/10/00 BY 6032

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

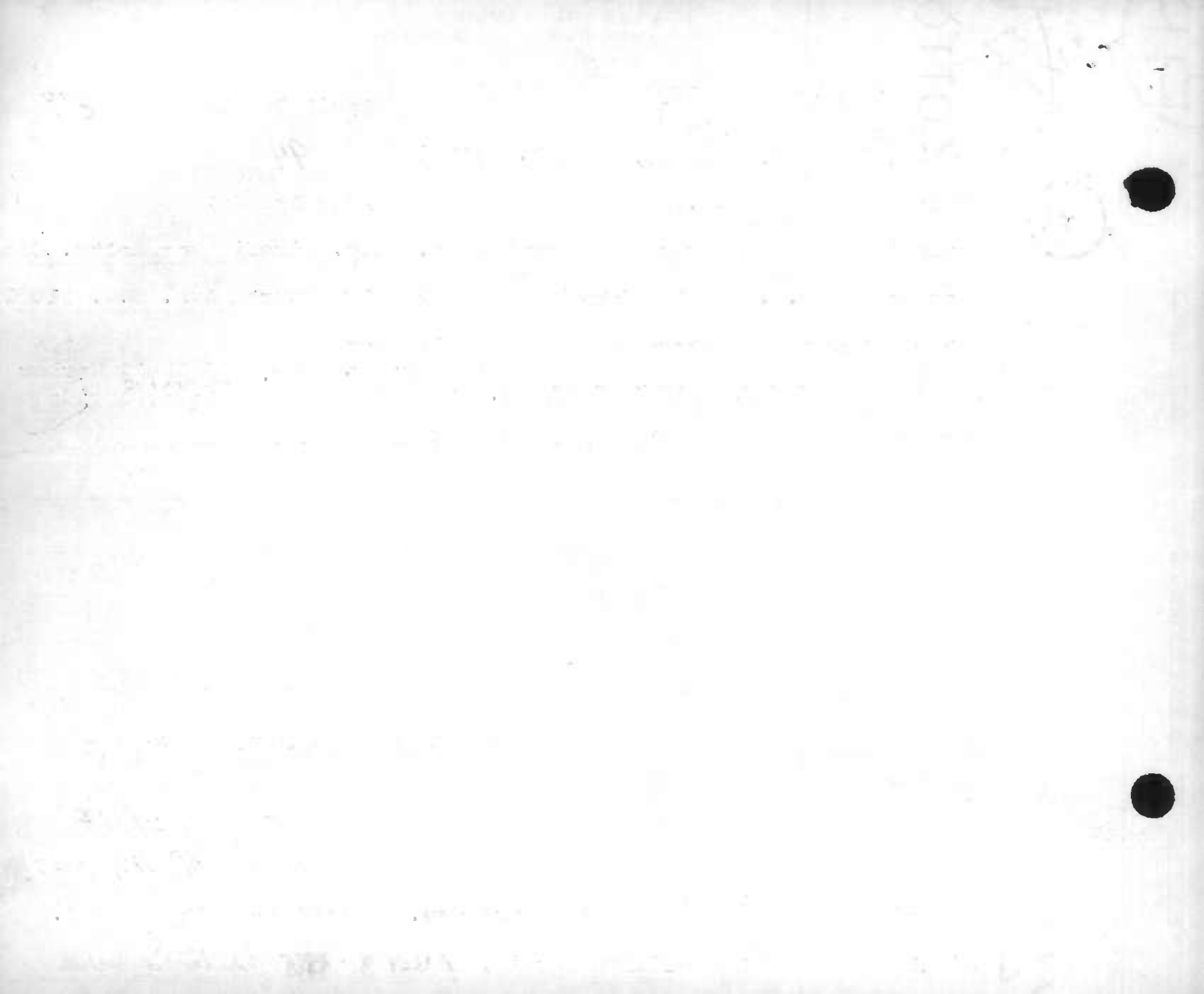
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09174

| | | | |
|---|--|--|--|
| 1- FOR STATE REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
Charles Jacob Peterson
CHARLES JACOB PETERSON | | 2a. DATE OF DEATH MONTH DAY YEAR
April 30, 1984 | |
| 3. SEX Male
MALE | | 4. RACE White
CAUCASIAN | |
| 5. DATE OF BIRTH MONTH DAY YEAR
Sept. 15, 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
94 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S..A | |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Firefighter | | 12b. KIND OF BUSINESS OR INDUSTRY
Balto. Cit. | |
| 13a. STATE
Maryland | | 13b. CITY OR TOWN
Glen Burnie | |
| 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13d. STREET ADDRESS / ZIP CODE
100 Fourth Ave. S.W. 21061 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Peter Peterson | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Unknown | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
216/34/7661 | |
| 17. INFORMANT (Grandson) ADDRESS
Mr. James Thompson Sr. Old Shell Harbor P.O. Box 640 Welaka, Florida | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4280 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
SEPSIS | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | |
| 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (U) (this hospital) attended the deceased from APR. 27, 1984, to APR. 30, 1984, that (U) (we) last saw the deceased alive on APR. 30, 1984, and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above, (U) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Barry R. Nathanson MD | | 22c. DATE SIGNED
5/1/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BARRY R. NATHANSON | | 22e. ADDRESS
51 FRANKLIN ST. ANNAP. MD. 21401 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
May 4, 1984 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore City Md. | |
| 24. FUNERAL DIRECTOR NAME
Singleton Funeral Home Glen Burnie, Md | | 25a. DATE RECD. BY REGISTRAR
MAY 3 1984 | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 9 1 7 5
REG. NO. | | | |
|--|--|----------------------|--|---|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Richard Burnell Phillips | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 4 22 84 | | 2b. HOUR M | | 2c. DATE PRONOUNCED DEAD 4 22 84 | | 2d. HOUR M | |
| 3. SEX M | | 4. RACE White | | 5. BIRTH June 6, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD 4 22 84 | | 7d. HOUR M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) IND | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH AA Co. | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hosp | | | | 12a. US. OCCUPATION, TYPE OF WORK, OR INDUSTRY Retiree | | 12b. KIND OF BUSINESS OR INDUSTRY Hydrolic | | | |
| 13a. STATE Md. | | | | 13b. COUNTY AA | | 13c. CITY OR TOWN Pasadena | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 134 Circle Rd. 21122 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Chester Phillips | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie D. Shepard | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. WW II | | 17. INFORMANT Lillian D. Phillips (wife) | | 17. ADDRESS same as 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Cardiac Arrest.
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
ASCVD
DUE TO, OR AS A CONSEQUENCE OF
(b)
(c) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | |
| ACTUAL SIGNATURE William P. Jones | | | | TITLE (SPECIFY) Deputy | | | | MEDICAL EXAMINER | | | | DATE SIGNED 4/22/84 | |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D. | | | | ADDRESS 695 America Ct Davidsonville 21035 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 25 Apr. 85 | | 23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie AA MD | | | |
| 24. FUNERAL DIRECTOR Singleton Funeral Home, Glen Burnie, MD | | | | 25a. DATE REC'D. BY REGISTRAR APR 24 1984 | | | | 25b. REGISTRAR'S SIGNATURE Galia Davidson-Randall | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09176

FOR
STATE
REGISTRAR

REG. NO.

EST

| | | | | | | | |
|---|---|---|--|--|--|-------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Charlie (CHARLES) Shelburne PINNIX | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 20, 1984 | | | 2b. HOUR
545 M | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 5, 1928 | 6. AGE (IN YEARS LAST BIRTHDAY)
56 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Virginia | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Management | | 12b. KIND OF BUSINESS OR INDUSTRY
N.S.A. | | |

| | | | | | |
|---|--|---|--|---|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE Maryland 13b. COUNTY A.A. 13c. CITY OR TOWN Glen Burnie | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX | 13e. STREET ADDRESS / ZIP CODE
1005 Guy Drive 21061 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William B. Pinnix | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Elizabeth Palmer | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
Korean 228.24.9645 | | 17. INFORMANT
Wife
Dorothy M. Pinnix
ADDRESS
Same as 13 | |

| | | |
|--|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>severe pneumonia</u>
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>metastatic lung cancer</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) _____ | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 d
9 months |
|--|--|---|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

| | | | | | |
|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-19</u> , 19 <u>84</u> , to <u>4-20</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>4-19</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<u>Long S. Hsu</u> | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN DIRECTOR PHYSICIAN | | | 22c. DATE SIGNED
Apr 20, 1984 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LONG S. HSU, M.D. | | 22e. ADDRESS
7845 OAKWOOD ROAD, SUITE 104
GLEN BURNIE, MARYLAND 21061 | | | |

| | | | |
|---|-------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | 23b. DATE
Apr 23, 84 | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Pk | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie AA MD |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home, Glen Burnie, MD | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
APR 24 1984 <u>[Signature]</u> | |

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WALL WARDEN COUNTY

WALL WARDEN COUNTY

Y. 10/10/10

CLY BENTLEY, MAY 10 1910
1011 CLAYTON ROAD, SUITE 104

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 09177 | |
|--|--|---|--|---|--|---|---|---|--------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Walter B. Pletcher, Jr. | | | | | 2a. DATE OF DEATH MONTH 4 DAY 6 YEAR 84 | | | 2b. HOUR A _M | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 7 DAY 19 YEAR 1912 | | 6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Phila. Pa. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Mayo | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4154 Shoreham Beach Rd. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Engineer | | 12b. KIND OF BUSINESS OR INDUSTRY Machine | | | |
| USUAL RESIDENCE 1 IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE 4154 Shoreham Beach Rd. 21106 | | | | |
| 13a. STATE MD. | | 13b. COUNTY A.A. | | 13c. CITY OR TOWN Mayo | | | | | | | |
| 14. FATHER'S NAME FIRST Walter MIDDLE B. LAST Pletcher, Sr. | | | | | 15. MOTHER'S MAIDEN NAME FIRST Henrietta MIDDLE Euson LAST | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAIVER DATES) WWII 065-09-7713 | | 17. INFORMANT Doris P. Pletcher | | | | | ADDRESS #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4449 IMMEDIATE CAUSE (a) malnutrition
DUE TO, OR AS A CONSEQUENCE OF (b) short bowel syndrome
DUE TO, OR AS A CONSEQUENCE OF (c) arterial embolism | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
mes
6-7-1980
6-7-1980 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chron. Atrial Fibrillation; Lt. hemiparesis due to CVA - | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-22 , 19 66 , to Present , 19 , that (I) last saw the deceased alive on 3-11 , 19 84 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above. He (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Peter F. Verkoum | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 4-6-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) PETER F. VERKOUW | | | | 22e. ADDRESS 419 Forest Dr. Annapolis Md 21403 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL Cremation | | 23b. DATE 4/9/84 | | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. MD. | | | | | |
| 24. FUNERAL DIRECTOR Taylor Funeral Chapel Annapolis Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR APR 11 1984 | | 25b. REGISTRAR'S SIGNATURE Davidson-Randell | | | |

171

(A)

1. The first part of the report deals with the general situation of the country. It is a very interesting and informative study of the country's development since 1945. The author has done a great deal of research and has collected a large amount of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's development.

2. The second part of the report deals with the economic situation of the country. It is a very interesting and informative study of the country's economic development since 1945. The author has done a great deal of research and has collected a large amount of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's economic development.

3. The third part of the report deals with the social situation of the country. It is a very interesting and informative study of the country's social development since 1945. The author has done a great deal of research and has collected a large amount of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's social development.

4. The fourth part of the report deals with the political situation of the country. It is a very interesting and informative study of the country's political development since 1945. The author has done a great deal of research and has collected a large amount of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's political development.

5. The fifth part of the report deals with the cultural situation of the country. It is a very interesting and informative study of the country's cultural development since 1945. The author has done a great deal of research and has collected a large amount of material. The report is well written and is easy to read. It is a valuable contribution to the study of the country's cultural development.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09178

1 - FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | |
|--|--|---|--|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
EDWARD M. PRESNELL | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 22, 1984 | | | 2b. HOUR
M
11 | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 6, 1929 | | 6. AGE (IN YEARS LAST BIRTHDAY)
54 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
WEST VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | |
| 10. CITY OR TOWN OF DEATH
SEVERNA PARK | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
269 ARUNDEL BEACH RD. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CIVIL ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
(GOV'T)
STATE OF MARYLAND | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
SEVERNA PARK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
EDWARD M. PRESNELL | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
DELLA MITCHELL | | 13e. STREET ADDRESS
269 ARUNDEL BEACH RD. | | 21146 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
KOREAN CONF. 213-26-0739 | | 17. INFORMANT
ADDRESS
ROMAINE PRESNELL (SAME AS 13) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Total body failure
1889
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost:
(b) Advanced rephrocy bladder cancer
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 8, 1984 to April 22, 1984 , that (I) (we) lost Edward M. Presnell above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
J. Fuchs | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
J. Fuchs | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
APRIL 25, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
CROWNSVILLE VETERAN CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
CROWNSVILLE ANNE ARUNDEL MD. | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT S. BARRANCO | | 501 RITCHIE HWY.
SEVERNA PARK, MD. | | 25a. DATE REC'D. BY REGISTRAR
APR 25 1984 | | 25b. REGISTRAR'S SIGNATURE
Lelia Davidson-Randall | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Registrar may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

90

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09179

EST

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
KATHERINE HELEN RAYMAN | | | 2a. DATE OF DEATH MONTH DAY YEAR
APRIL 5, 1984 | | | 2b. HOUR
2:14 PM | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 27, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurses Aide | | | |
| | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Retired | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John Reid | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Unknown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
no | | | 16b. SOCIAL SECURITY NO.
217-14-3347 | | 17. INFORMANT
ADDRESS
Elinora Case same as 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Respiratory Failure</u>
4292
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Arteriosclerotic Cardiovascular Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Congestive Heart Failure</u> | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>2 week</u>
<u>5 year</u>
<u>5 year</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:
<u>Pneumonia</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (we) attended the deceased from <u>4/5/84</u> 19 <u>84</u> , to <u>4/10/84</u> 19 <u>84</u> , that (I) (we) saw the deceased alive on <u>4/5/84</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 27b. SIGNATURE
<u>Elliott Gorbaty, M.D.</u> | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 27c. DATE SIGNED | | | |
| 27d. PHYSICIAN'S NAME (TYPE OR PRINT)
ELLIOTT GORBATY, M.D. | | | 27e. ADDRESS
7845 OAKWOOD ROAD, #203
GLEN BURNIE, MARYLAND 21061 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
9 April 84 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. MD. | | | |
| 24. FUNERAL DIRECTOR
NAME
James S. Kirkley Glen Burnie MD. | | | | 25a. DATE REC'D. BY REGISTRAR
APR 9 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>Julia Davidson-Randall</u> | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6
A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 09180 | |
|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE OF DEATH | | 2b. HOUR |
| LEE ROBERT REEDER, SR. | | | APRIL 21, 1984 | | 0952A.M. |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. |
| Male | White | July 18, 1916 | 67 YRS. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | | ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | Self Employed | | Junk Business |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS |
| Maryland | | A. A | Glen Burnie | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 1401 Dorsey Road 21061 |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | |
| FIRST MIDDLE LAST
? ? Reeder | | FIRST MIDDLE LAST
U N K N O W N | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| no | | 219-01-5571 | | Elsie Eleanor Reeder same as above | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1: DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarct</u>
4100
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
<u>GASTROINTESTINAL BLEED, Peleles</u> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
<u>Fred Kahn M.D.</u> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| FRED T. KAHN, M.D. | | 7575 RITCHIE HIGHWAY, SE. | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION
CITY OR TOWN COUNTY STATE | |
| Burial | | 4/24/1984 | Meadowridge Mem. Pk/ | Elkridge, Howard. Md. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Raymond C. Fink Glen Burnie, Md. | | APR 23 1984 | | <u>a Davidson-Randall</u> | |

BP _____



WILKINSON

20% COTTON



WILKINSON COTTON CO. INC. NEW YORK, N.Y.
WILKINSON COTTON CO. INC. NEW YORK, N.Y.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | |
|--|--|------------------|-----------------|--|--|---|--|---|---------------------|---|--|---|--|--|-----------------------|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | FIRST
Justin | | | MIDDLE
Stuart | | | LAST
Rhodes, Sr. | | | 2a. DATE KNOWN OF DEATH
<input checked="" type="checkbox"/> ESTIMATED
4-15 1984 | | | 2b. HOUR
M | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Oct. 20, 57 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY)
26 YRS. | | IF UNDER 1 YR.
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
4-15 1984 | | | 2d. HOUR
1:40 a.m. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Special Police | | | | 12b. KIND OF BUSINESS OR INDUSTRY
State of MD | | | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
(21061)
454 Glen Mar Rd. Apt A2 | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
John D. Rhodes, Jr. | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Betty M. List | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
213.64.0203 | | 17. INFORMANT
Wife
Cynthia L. Rhodes
ADDRESS
Same as 13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cranio-cerebral Injuries</u>
8160
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.
(b) _____
(c) _____
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF
DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
12:47x 4-15 1984 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
driver lost control and impacted fixed object | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)
road | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Gambrills Rd. south of Dicus Rd., Gambrills, Anne Arundel Co., Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
<i>Margarita A. Korell</i> | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | | | | | DATE SIGNED
4-16-84 | | | | | |
| EXAMINER'S NAME
(TYPE OR PRINT)
Margarita A. Korell, MD | | | | ADDRESS
111 Penn Street | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | 23b. DATE
April 18, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Pk | | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie, AA MD | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
<i>ABV</i> | | | | ADDRESS
Singleton Funeral Home, Glen Burnie, MD | | | | 25a. DATE REC'D BY REGISTRAR
APR 17 1984 | | | | 25b. REGISTRAR'S SIGNATURE
<i>Julia Davidson-Rendell</i> | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09182

FOR
1- STATE
REGISTRAR

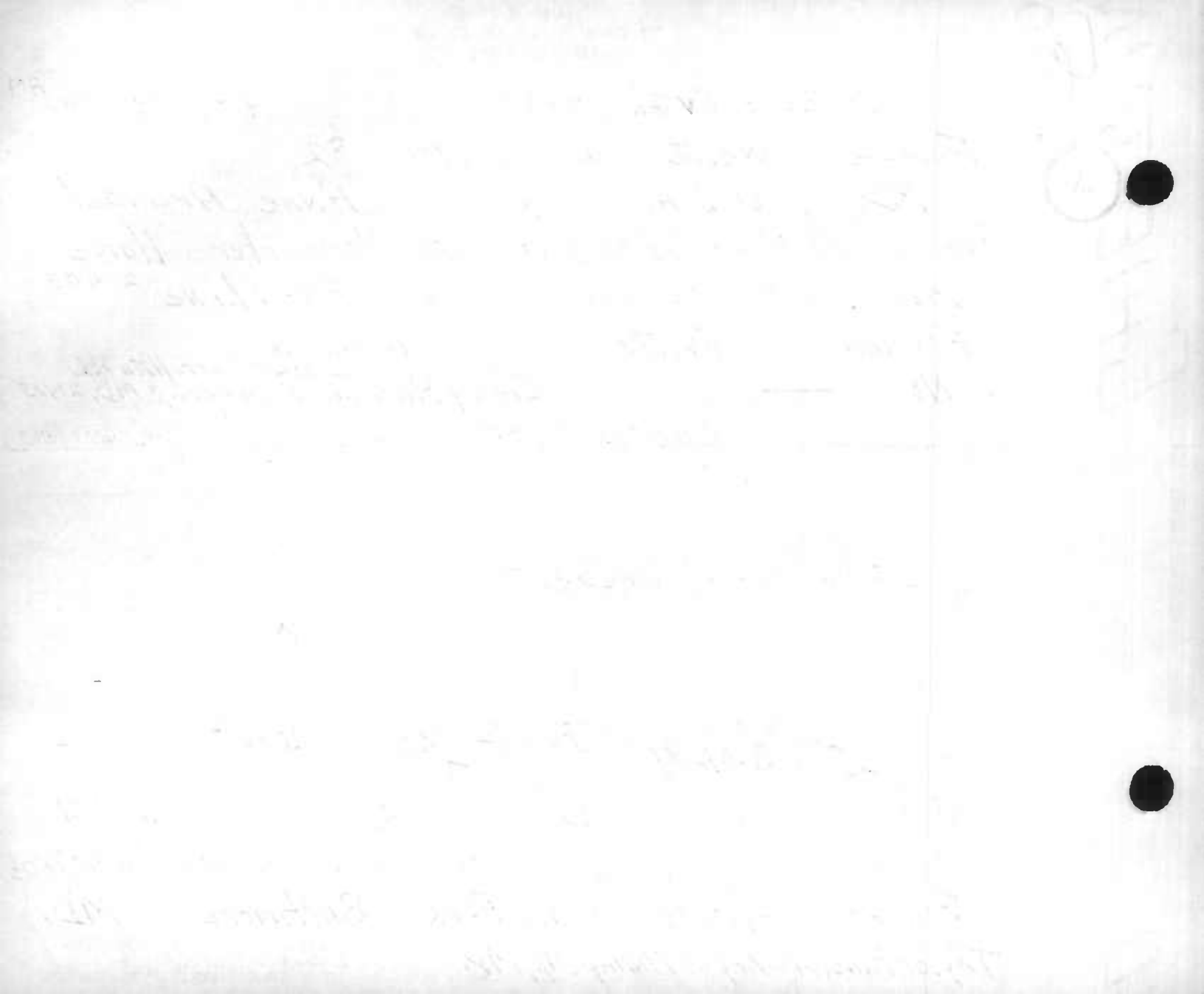
REG. NO.

| | | | | | | | |
|---|--|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ESTELLE SVITAK RICE | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4-7-84 | | | 2b. HOUR
7:40 AM | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 12, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Crownsville | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fairfield Nursing Center | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. STATE
MD. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Florian SVITAK | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
UNKNOWN | | 13e. STREET ADDRESS / ZIP CODE
Eden Lane 21403 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES) | | 17. INFORMANT
ADDRESS
Emory Rice, Jr. 2545 Carrollton Rd.
Annapolis, MD, 21403 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4299 IMMEDIATE CAUSE (a) Sudden Death (Cardiac)
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
INSTANTANEOUS | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):
DEMENTIA - DECUBITI | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
Fall of 83 Present | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 3-14-84 to 4-7-84, that (I) (we) saw the deceased alive on 3-14-84, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 23a. SIGNATURE
PETER F. LERKOWSKI MD | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4-7-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER F. LERKOWSKI MD | | 22e. ADDRESS
1419 Forest Drive Annapolis, MD, 21403 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
4/10/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore MD. | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Taylor Funeral Chapel Annapolis, MD. | | 25a. DATE REC'D. BY REGISTRAR
APR 11 1984 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
John Davidson-Rendell | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 9183 | | | |
|--|--|--------------------|--|--|--|--|--|--|---------------------------|---|--|-------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) DAVID CARLTON ROBBINS | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 4 8 1984 | | 2b. HOUR M | |
| 3. SEX m | | 4. RACE CAU | | 5. DATE OF BIRTH 4 19 13 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | 7c. DATE PRONOUNCED DEAD 4 8 1984 | | 2d. HOUR 0202 M | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Contractor | | 12b. KIND OF BUSINESS OR INDUSTRY Const. | | | |
| 13a. STATE Md. | | | | 13b. COUNTY AA | | 13c. CITY OR TOWN Glen Burnie | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 501 Mayo Road - 21061 | | | |
| 14. FATHER'S NAME FIRST Moses MIDDLE Henry LAST Robbins | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Martha MIDDLE = LAST Lynch | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes | | | | 16b. SOCIAL SECURITY NO. ww-2 212-16-9499 | | 17. INFORMANT ADDRESS Eileen M. Robbins same as above | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART 1 DEATH WAS CAUSED BY:
4292 Cardiac Arrest
IMMEDIATE CAUSE (a) ASCVD
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) ASCVD
(c) ASCVD | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | |
| ACTUAL SIGNATURE William P. Jones, M.D. | | | | | | TITLE (SPECIFY) Deputy | | | DATE SIGNED 4/8/84 | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) William P. Jones, M.D. | | | | | | ADDRESS 695 America Ct Davidsonville 21035 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 4/10/84 | | 23c. NAME OF CEMETERY OR CREMATORY Meadowridge Mem. Pk. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Elkridge, Howard. Md. | | | |
| 24. FUNERAL DIRECTOR NAME Raymond U. Fink ADDRESS Glen Burnie, Md. | | | | | | 25a. DATE PREPARED BY REG. NO. APR 9 1984 25b. REGISTRAR'S SIGNATURE John Davidson-Randall | | | | | | | |

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ASGUD
Gardine Arrest

FREE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | 09184 | |
|--|--|---|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT)
HARRY M. ROHRBACH | | | | 2a. DATE OF DEATH MONTH DAY YEAR
4-13-84 | | |
| 3. SEX
Male | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
4 12 09 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PA. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 6. AGE (IN YEARS, LAST BIRTHDAY)
75 YRS. | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Gen. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)
Wholesale | | 12b. KIND OF BUSINESS OR INDUSTRY
Food | | 12c. ADDRESS / ZIP CODE
21401 | | |
| 13a. STATE
MD. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Harry L. Rohrbach | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Agnes Magee | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
048-01-4203 | | 17. INFORMANT ADDRESS
Ruth Wing Rohrbach #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
2041 IMMEDIATE CAUSE (a) Chronic lymphocytic leukemia
DUE TO, OR AS A CONSEQUENCE OF (b) _____
DUE TO, OR AS A CONSEQUENCE OF (c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
8 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 75, to April 13, 19 84, that (I) (we) last saw the deceased alive on April 13, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
Stuart E. Selowick, M.D. | | | | 22c. DATE SIGNED
4/15/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stuart E. Selowick | | | | 22e. ADDRESS
51 Franklin St. Annapolis, Md. | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)
BURIAL | | 23b. DATE
4/17/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Davidsonville Meth. | | |
| 24. FUNERAL DIRECTOR NAME
Taylor Funeral Chapel | | 24b. ADDRESS
ANNAPOLIS, MD. | | 25. RECEIVED BY REGISTRAR
APR 18 1984 | | |
| 25a. REGISTRAR'S SIGNATURE
John Davidson-Randall | | 25b. REGISTRAR'S SIGNATURE | | | | |

BP _____

THE UNIVERSITY OF CHICAGO
LIBRARY
12-2-27
MAY 11 1928
PHOTOGRAPHED BY THE UNIVERSITY OF CHICAGO
HARRY L. ROBINSON
NO. 1 - OVER THE ROAD WAGON - 12
THANK YOU FOR THE
LIBRARY OF THE UNIVERSITY OF CHICAGO
HARRY L. ROBINSON
NO. 1 - OVER THE ROAD WAGON - 12
THANK YOU FOR THE
LIBRARY OF THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

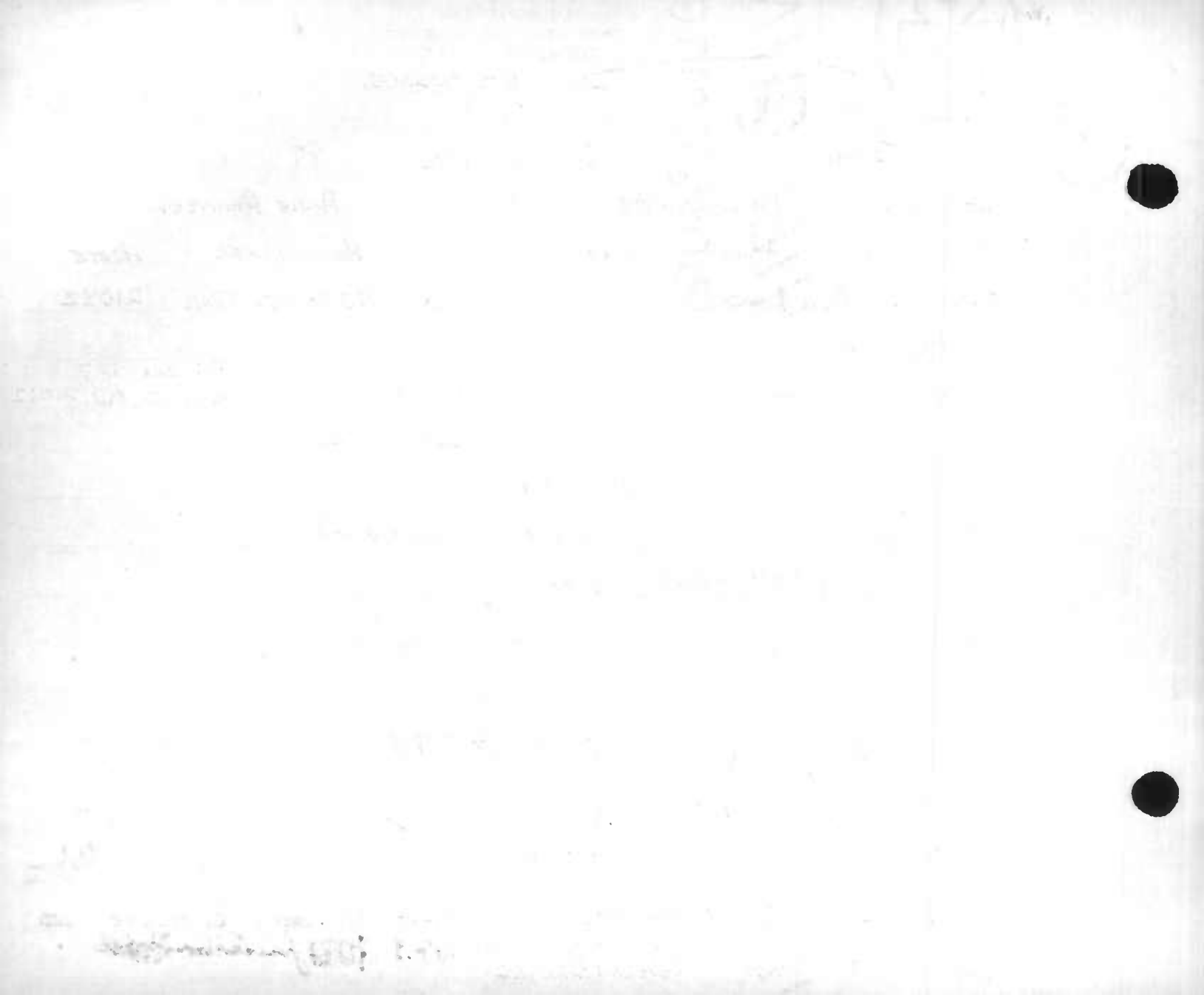
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/83
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | | | |
|---|--|---|--|---|--|---|--|--|--|---|--|---------------------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ROSENDALE, E HELEN | | | | | | | | | | DATE OF DEATH
MONTH 4 DAY 5 YEAR 84 | | 2b. HOUR
8:30 M | |
| 3. SEX
FEMALE | | 4. RACE
CAUC | | 5. DATE OF BIRTH
MONTH JULY DAY 19 YEAR 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNA CONV CTR | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | 12b. KIND OF BUSINESS OR INDUSTRY
HOME | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | |
| 13a. STATE
MARYLAND | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
CROWNSTOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
393 LAUREL TRAIL | | 21032 | | | |
| 14. FATHER'S NAME
FIRST UNKNOWN MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME
FIRST UNKNOWN MIDDLE LAST | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
 | | 17. INFORMANT
MARGARET SPURLIN | | ADDRESS
P.O. Box 127 | | ARNOLD, MD. 21012 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY
4029 IMMEDIATE CAUSE (a) abrupt accident
DUE TO, OR AS A CONSEQUENCE OF
(b) HA50V0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) CHF, chronic | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
PARACINSON'S Disease | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from Approx 12 , 19 83 , to 4:5 , 19 84 , that (1) (we) lost saw the deceased alive on 4:1 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Michael J. LaPenta MD | | | | DEGREE
MD | | | | 22c. DATE SIGNED
4/5/84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL J. La Penta MD | | | | 22e. ADDRESS
703 GIDDINGS AVE ANNAPOLIS MD | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
APRIL 7, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
WOODLAWN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
WOODLAWN BALTIMORE MD | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT S. BARRANCO | | | | | | | | | | | | | |

501 RITCHIE HWY. SEVERNA PARK, MD.
APR 1 1984



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 09186 | | | |
|---|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR | | | | 2a DATE OF DEATH MONTH DAY YEAR 4 7 84 | | | |
| 1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BIRDELLA MARY JENNINGS ROSS | | | | 2b HOUR M | | | |
| 3 SEX FEMALE | | 4 RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 7 17 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA | | 7b CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE A.A. CO. MD. | |
| 10 CITY OR TOWN OF DEATH BALTO. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 9 JACKSON AVE. | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b KIND OF BUSINESS OR INDUSTRY | |
| 13a STATE MD. | | | | 13b COUNTY | | 13c CITY OR TOWN BALTO. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST ALBERT JENNINGS | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH JEENINGS | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b SOCIAL SECURITY NO. 213-20-6050 | | 17. INFORMANT ADDRESS YVONNE WILLIAMS 3209 NORTHMONT RD. 21207 | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4439 CARDIO RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) Peripheral vascular disease yrs
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-15, 19 83, to 2-8, 19 84, that (I) (we) last saw the deceased alive on Feb 8, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE M. Inayatullah, M.D. | | | | DEGREE | | 22c. DATE SIGNED 4/10/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS 333 St. Paul Street Baltimore, MD 21202 | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 4/12/84 | | 23c. NAME OF CEMETERY OR CREMATORY NEW CATHEDRAL CEM. | | 23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD. | |
| 24 FUNERAL DIRECTOR LEROY O. DYETT 4600 LIBERTY HGTS. AVE. | | | | 25a. DATE REC'D. BY REGISTRAR APR 10 1984 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE | | | |

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1945-1946



20% COTTON

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1945-1946

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

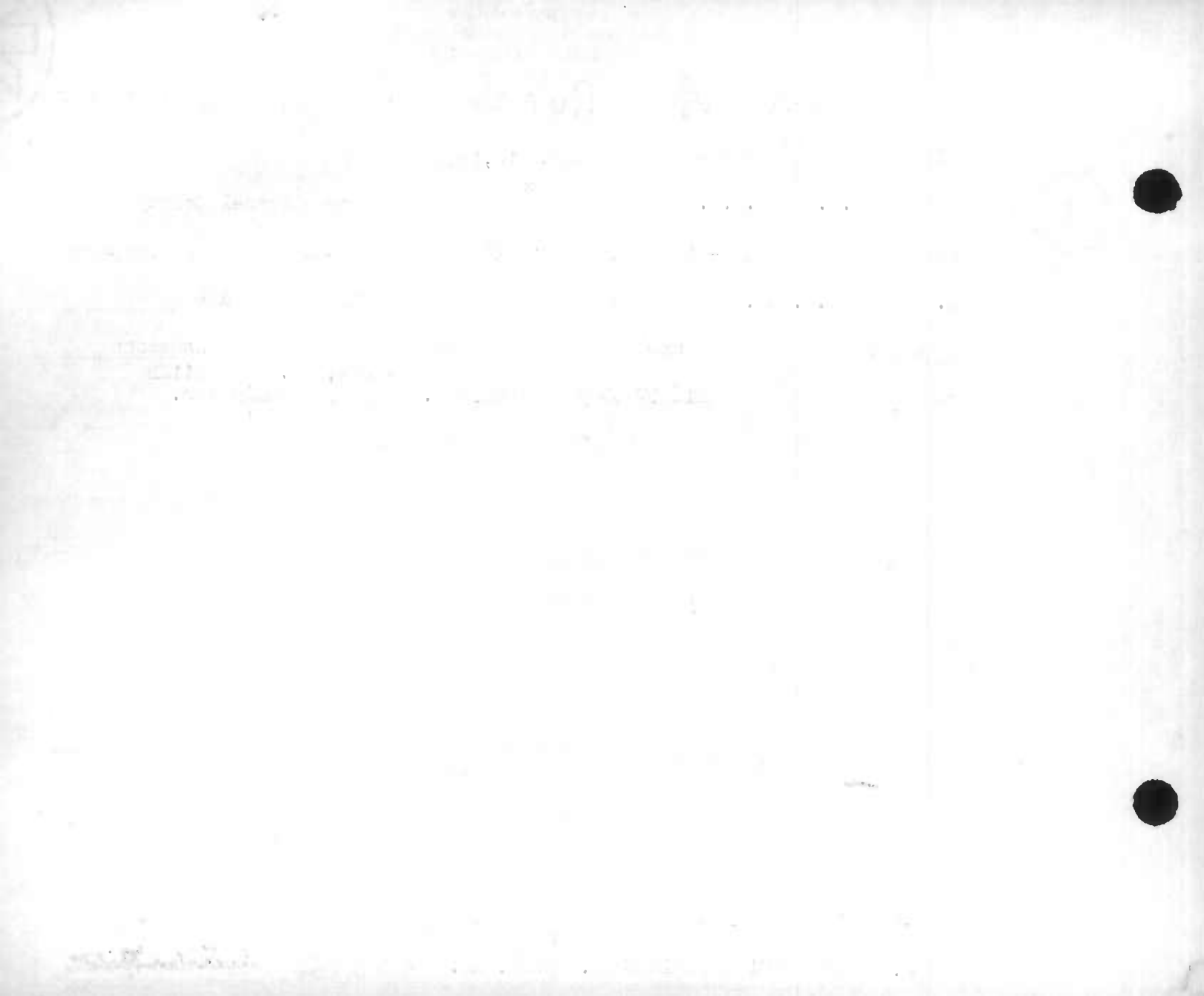
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and set out.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | | |
|--|--|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) GARLAND A. RUARK | | | 2a. DATE OF DEATH MONTH DAY YEAR
APRIL 21 '84 | | | 2b. HOUR
2 A M | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Sept 16, 1913 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Washington D.C. | | 9. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | |
| 10. CITY OR TOWN OF DEATH
Pasadena | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Home - 1564 Park Lane 21122 | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Editor | | 12b. KIND OF BUSINESS OR INDUSTRY
Newspaper | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Md. | | 13b. COUNTY
A.A. Co. | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1564 Park Lane 21122 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Samuel Ruark | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ethel Anderson | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
216 07 6065 | | 17. INFORMANT Pasadena, Md. ADDRESS 21122
Thomas W. Ruark 708 Holly Ave. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CA COLON
1539
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last }
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 83 , 19 _____, to 4/21/84 , 19 _____, that (I) last saw the deceased alive on 4/10/84 , 19 _____, and that in (my) my opinion death occurred on the date and hour and from the causes stated above, (I) did not view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
S. P. WATKINS | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/21/84 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Cremation | | | 23b. DATE
4/23/84 | | 23c. NAME OF CEMETERY OR CREMATORY
WESTVIEW MEMORIAL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BALTIMORE MARYLAND | | |
| 24. FUNERAL DIRECTOR
NAME
GEORGE J. GONCE | | | | | ADDRESS
4001 RITCHIE HWY. BALTO. MD. 21225 | | 25a. DATE REC'D. BY REGISTRAR
APR 23 1984 | | |
| 25b. REGISTRAR'S SIGNATURE
John Anderson | | | | | | | | | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was retained by the hospital or attending physician, this certificate has been signed by the attending physician and completely filled in by the funeral director. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 is marked, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09188

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|--|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
FLOYD A. RYAN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4-9-84 | | 2b. HOUR
11:15 M |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
MONTH DAY YEAR
2-12-91 | 6. AGE (IN YEARS (LAST BIRTHDAY))
83 YRS. | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL Co. MD. | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL General | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
FOREMAN EASTMAN KODAK | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MARYLAND | | | 13b. COUNTY
ANNE ARUNDEL | 13c. CITY OR TOWN
CROFTON | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM R. RYAN | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JENNIE ROOT | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
073-09-5302 | | 17. INFORMANT
ADDRESS
GERALD RYAN SAME AS 13C | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) pneumonia
4860
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
cerebro-vascular accident | | | | | |
| 19a. DATE OF OPERATION
none | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
N/A | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
N/A | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
N/A | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NO WHILE <input checked="" type="checkbox"/> AT WORK
N/A | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
N/A | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
N/A | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/9 19 84 , to 4/9 19 84 , that (I) (we) lost
saw the deceased alive on 4/9 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Thomas Walsh MD | | DEGREE
MD | | 22c. DATE SIGNED
4-11-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
THOMAS M. WALSH MD | | 22e. ADDRESS
264 Peninsula Farm Road Annapolis Md 21012 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
4-13-84 | | 23c. NAME OF CEMETERY OR CREMATORY
ROSE HILL | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rock Hill HARTFORD CONN | | 24. FUNERAL DIRECTOR
NAME ADDRESS
ROBERT E. EVANS ANNAPOLIS MD | | | |

BP

APR 18 1984 Julia Davidson-Randall



[The page contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is scattered across the page and is not readable.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 09189 | |
|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | EST | |
| 1. DECEASED NAME | | | | 2a. DATE OF DEATH | |
| FIRST MIDDLE LAST | | | | MONTH DAY YEAR | |
| CASMER ADAM SABLOWSKI | | | | APRIL 18, 1984 | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| Male | | White | | MONTH DAY YEAR | |
| | | | | Aug. 4, 1915 | |
| 6. AGE | | 7a. BIRTHPLACE | | 7b. CITIZEN OF WHAT COUNTRY? | |
| (IN YEARS LAST BIRTHDAY) | | (STATE OR FOREIGN COUNTRY) | | (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | |
| 68 | | Maryland | | U.S.A. | |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 12a. USUAL OCCUPATION | |
| | | ANNE ARUNDEL COUNTY MD. | | (TYPE OF WORK FOR MOST OF WORKING LIFE) | |
| | | | | Fire Inspector | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | 12c. KIND OF BUSINESS OR INDUSTRY | | 12d. KIND OF BUSINESS OR INDUSTRY | |
| | | | | Beth. Steel | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | |
| GLEN BURNIE | | | | NORTH ARUNDEL HOSPITAL | |
| 13a. STATE | | | | 13b. COUNTY | |
| Maryland | | | | A.A. | |
| 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | |
| Glen Burnie | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | |
| John Sablowski | | | | Jennie Jablonski | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | |
| (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | |
| Yes W.W. II | | | | 212/09/6037 | |
| 17. INFORMANT (Wife) | | | | ADDRESS | |
| Mrs. Frances Sablowski | | | | Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) Cardiovascular arrest | | | | | |
| 4140 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular fibrillation | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) A Sudden | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| Renal Failure | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| | | | | 4116/194 4/18/84 | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/18/84 to 4/19/84, that (I) (we) lost | | | | | |
| saw the deceased alive on 4/18/84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated | | | | | |
| 22b. SIGNATURE | | | | | |
| Jorge B. Ramirez, M.D. | | | | | |
| 22c. ADDRESS | | | | | |
| 7845 OAKWOOD ROAD, SUITE 205 GLEN BURNIE, MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| Burial | | April 21, 1984 | | Glen Haven Mem. Prk. | |
| 24. FUNERAL DIRECTOR | | 24a. DATE REC'D. BY REGISTRAR | | 24b. REGISTRAR'S SIGNATURE | |
| NAME ADDRESS | | APR 24 1984 | | WILLIAM G. GAY | |
| Singleton Funeral Home Glen Burnie, Md. | | | | | |

BP



[Faint, mostly illegible text and markings on lined paper. Includes handwritten notes, a large circular stamp, and various scribbles.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09190

FOR
1- STATE
REGISTRAR

REG. NO.

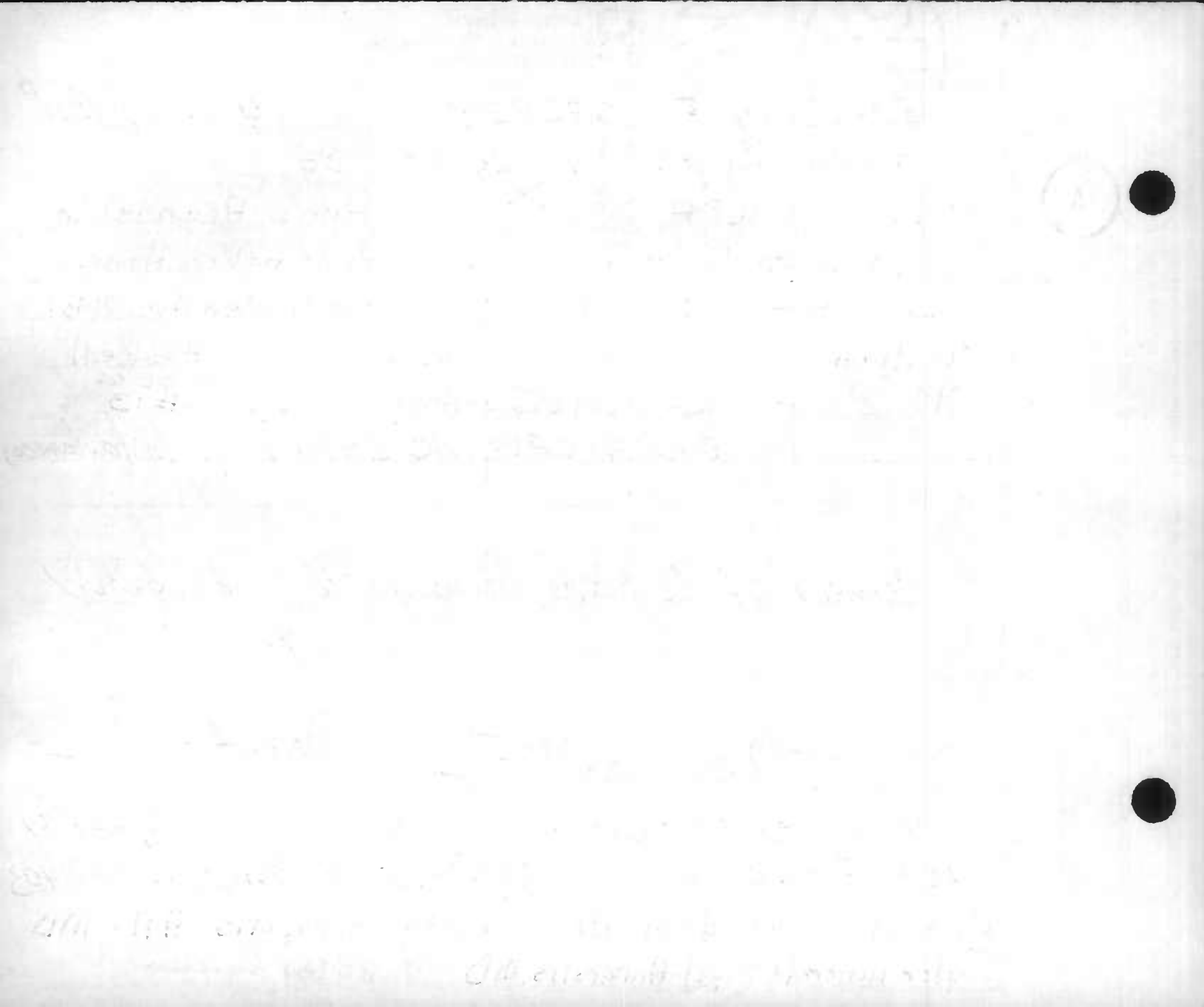
| | | | | | | | |
|---|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ELIZABETH F. SACREY | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 22 84 | | | 2b. HOUR
12:30 P | |
| 3. SEX
Female | | 4. RACE
Cauc. | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 24 97 | | 6. AGE (IN YEARS-LAST BIRTHDAY)
86 | |
| 7c. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MD | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
308 N. Glen Avenue | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | |
| 13a. USUAL RESIDENCE
13a. STATE
MD | | 13b. COUNTY
AN. A. | | 13c. CITY OR TOWN
Annapolis | | 13d. STREET ADDRESS / ZIP CODE
308 N. Glen Ave. 21401 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Farish | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Maude Haskell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES
(YES OR NO) (IF YES, GIVE WAR OR DATES)
NO. | | 16b. SOCIAL SECURITY NO.
212-743392 | | 17. INFORMANT
J. Lindsay Sacrey | | ADDRESS
Same as #13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for 18a, 18b, and 18c.)
PART I. DEATH WAS CAUSED BY
4299 IMMEDIATE CAUSE (a) SUDDEN CARDIAC DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Cancer of the spine, primary site unknown | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
8:30 P.M. 1984 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHERE <input type="checkbox"/> AT HOME <input type="checkbox"/>
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
CITY OR TOWN COUNTY STATE
Preston | | | |
| 22. I certify that (1) (the hospital) attended the deceased from 8/23/84 to Present 19____, that (1) (the hospital) saw the deceased alive on 8/23/84 19____ and that in (my) own opinion death occurred on the date and hour and from the causes stated. | | | | | | | |
| 22a. SIGNATURE
Peter F. Verkouw | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/22/84 | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER F. VERKOUW | | 22d. ADDRESS
1419 FOREST DR. Annapolis, Md 21403 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Apr. 25, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Bluff | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Annapolis AN. MD | |
| 24. FUNERAL DIRECTOR
NAME
Taylor Funeral Chapel-Annapolis, MD | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
APR 26 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Two please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09191

| | | | |
|---|--|--|---|
| 1. FOR
STATE
REGISTRAR | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) ARTHEME JOSEPH ST. MARTIN, JR | | 2a. DATE OF DEATH
MONTH 4 DAY 9 YEAR 84 2b. HOUR 820p M | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH 5 DAY 15 YEAR 1896 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) CANADA | 7b. CITIZEN OF WHAT COUNTRY? USA. | 6. AGE (IN YEARS LAST BIRTHDAY)
87 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 10. CITY OR TOWN OF DEATH
LINTHICUM | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
449 Kingwood Rd. | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CARPENTER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE MD 13b. COUNTY BALTO CITY 13c. CITY OR TOWN BALTIKORE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2605 GIBBONS AVE 21214 | |
| 14. FATHER'S NAME
FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN | | 15. MOTHER'S MAIDEN NAME
FIRST UNKNOWN MIDDLE UNKNOWN LAST UNKNOWN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | | 16b. SOCIAL SECURITY NO.
218011528 | |
| 17. INFORMANT
Mr. Artheme J. St. Martin, Jr., 449 Kingwood Rd | | ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
YEARS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) NONE | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | |
| 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2-17 , 19 84 , to 4-9 , 19 84 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Laurence R. Gallagher, MD | | 22c. DATE SIGNED
4-9-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
LAURENCE R. GALLAGER | | 22e. ADDRESS
STAGNES MED CTR, WILKENS AND PINE HTS, BALTIMORE 21229 MD. | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | 23b. DATE
4-12-84 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Gardens of Faith | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore Maryland | |
| 24. FUNERAL DIRECTOR
NAME Leonard J. Ruck, Inc. ADDRESS Baltimore, Md. | | 25a. DATE REC'D. BY REGISTRAR APR 10 1984 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | |

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D. C.

A

APR 1 1904

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09192

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Julia K. Scarborough | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 15, 1984 | | | 2b. HOUR
12:30 | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
February 28 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS. | |
| 7a. BIRTH PLACE (STATE OR FOREIGN)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Nurse | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Nursing | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD. | | | | | |
| 13b. CITY OR TOWN
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
2012 FERRY FARM RD 21401 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Theodore A. KAUFFMAN | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
FANNIE ELISABETH Baker | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
WA I 213 74 5531 | | 17. INFORMANT
ADDRESS
1120 ESTELLE ST. 39401
WILLIAM SCARBOROUGH HATTIESBURG MISS. | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

5990

DUE TO, OR AS A CONSEQUENCE OF

(b) Probable Gram \ominus bacillus

DUE TO, OR AS A CONSEQUENCE OF

(c) urinary tract infection

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)

1. methicillin bacteria 2. hypotension 3. severe feeding abn.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-14-84, 19 to 4-15, 1984, that (I) (we) lost
saw the deceased alive on 4-14, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
E. A. Phillips | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4-15-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ERROL A. Phillips MD | | 22e. ADDRESS
20 Ridgely Ave, Annapolis MD | | | | | |

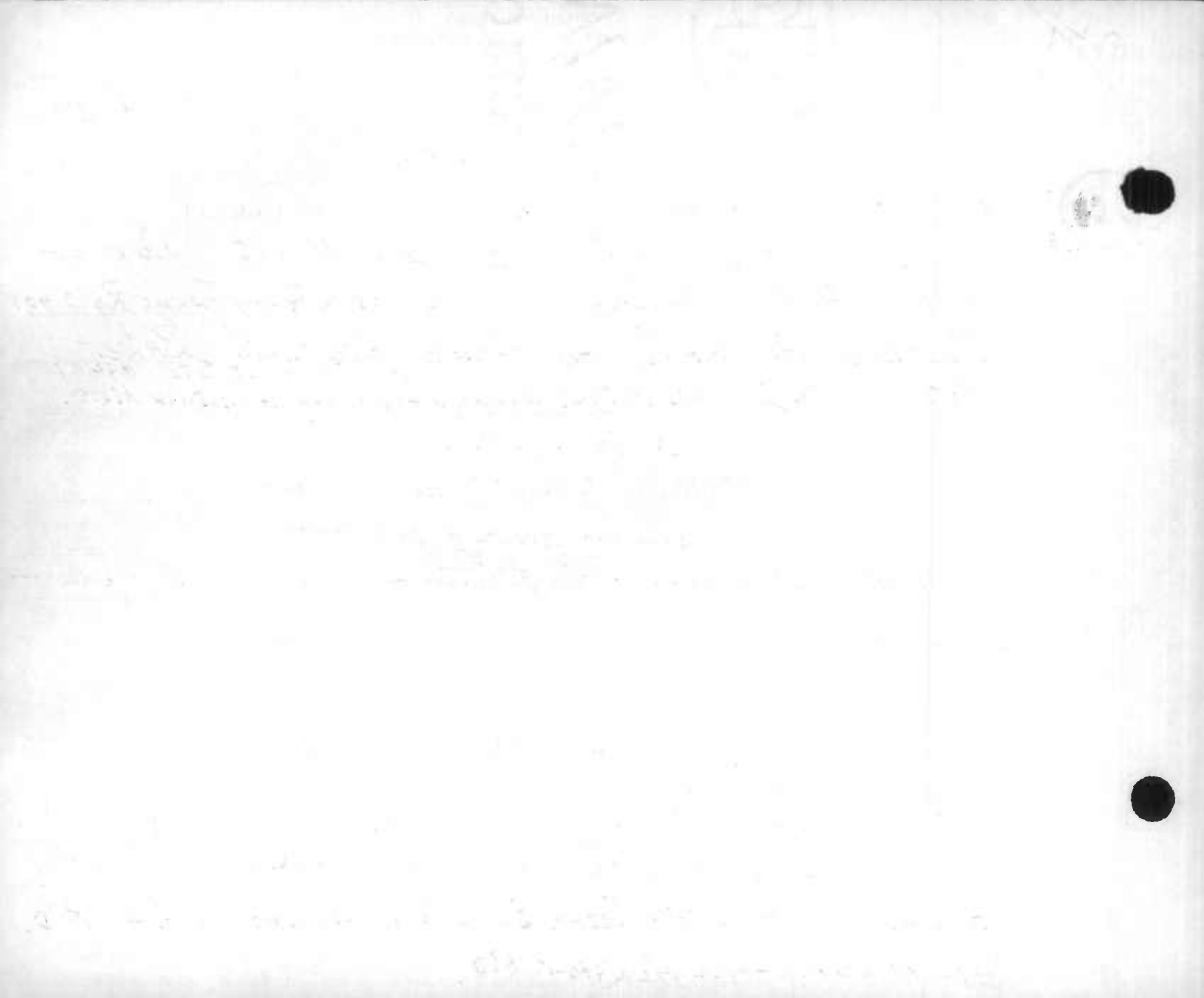
| | | | | | | | |
|--|--|------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | 23b. DATE
4-19-1984 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR BLUFF Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY
Annapolis AA. MD. | |
| 24. FUNERAL DIRECTOR
NAME
TAYLOR FUNERAL CHAPEL ANNAPOLIS MD | | | | 25a. DATE REC'D. BY REGISTRAR
APR 18 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | REG. NO. | |
|---|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
ADELAIDE A. SCHANKEN | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 17 84 | | 2b. HOUR
8:06 PM | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
2 13 98 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Md. Manor Conv. Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
--- | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Pasadena | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS
7731 Vena Court 21122 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George Seebold | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Emma Miegel | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
213-74-4884 | | 17. INFORMANT ADDRESS
Clarence E. Schanken 7731 Vena Ct. 21122 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1991 IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CANCER</u>
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | |
| PART 2: OTHER SIGNIFICANT CONDITIONS <u>CONTRIBUTING TO DEATH</u> BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
<u>Peter H. Rheinwein</u> | | | | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/17/84 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER RHEINSTEIN | | | | 22e. ADDRESS
621 HOLLY RIDGE RD. SEVERNA PARK | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4/20/84 | 23c. NAME OF CEMETERY OR CREMATORY
Meadowridge Mem. Pk. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Elkridge Howard Maryland | |
| 24. FUNERAL DIRECTOR
NAME
Hubbard Funeral Home, Inc. 4107 Wilkens Ave. | | | | 25a. DATE REC'D BY REGISTRAR
APR 19 1984 | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09194

FOR
STATE
REGISTRAR

REG. NO.

EDT

| | | | | | | | |
|--|--|---|--|---|----------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
WALLACE R. SCHUTT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 20, 1984 | | 2b. HOUR
12:20 M | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
12 3 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS MONTHS DAYS
68 | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
OHIO | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CREDIT COLLECTOR | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MD. | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
EDGEWATER | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
THOMAS L. SCHUTT | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
HELEN M. GARVER | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
564 12 8296 | |
| 17. INFORMANT
ADDRESS
HELEN P. BAER #13 | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
4860 Bilateral Extensive
IMMEDIATE CAUSE (a)
DUE TO, OR AS A CONSEQUENCE OF
(b) Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/18/84 to 4/20/84 , that (I) (we) last saw the deceased alive on 4/18/84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Recep Erol | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
RECEP EROL, M.D. | | 22e. ADDRESS
325 HOSPITAL DRIVE, #104
GLEN BURNIE, MD. 21090 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK ONE)
CREMATION | | 23b. DATE
4/23/84 | | 23c. NAME OF CEMETERY OR CREMATORY
CEPAR HILL | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Suitland P.G. MD. | |
| 24. FUNERAL DIRECTOR
NAME
Taylor Funeral Chapel | | ADDRESS
Annapolis Md. | | 25a. DATE REC'D. BY REGISTRAR
APR 26 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Robert | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner number is marked at top.

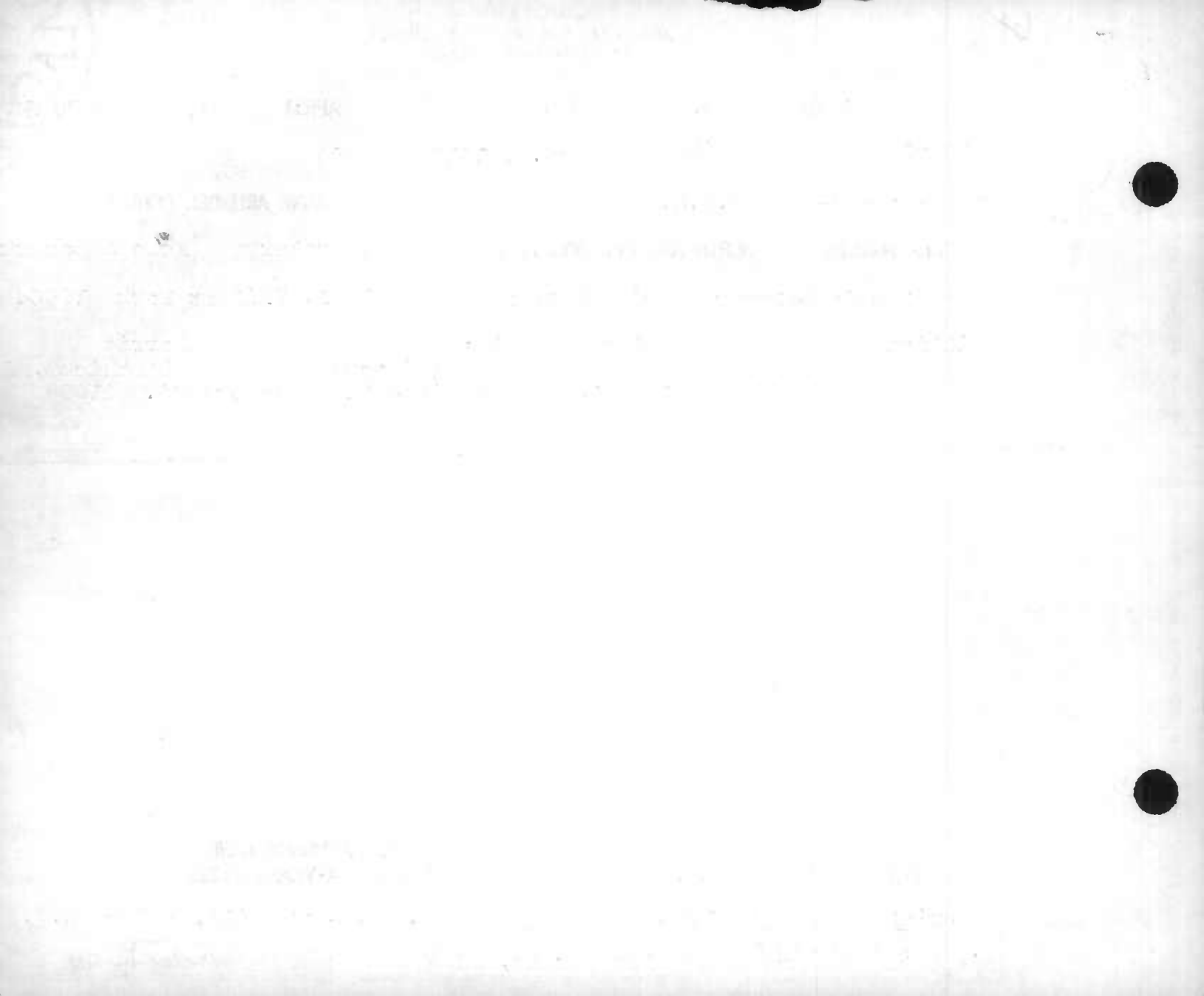
BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

| | | | | | | | | | | |
|--|--|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MILDRED A SCOTT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 27, 1984 | | | 2b. HOUR
0520 PM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 3, 1919 | | 6. AGE (IN YEARS LAST BIRTHDAY)
64 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Secretary | | 12b. KIND OF BUSINESS OR INDUSTRY
Acme Supermrk | | |
| 13a. STATE
Pennsylvania | | | 13b. COUNTY
Delaware | | 13c. CITY OR TOWN
Springfield | | 13d. INSIDE CITY LIMITS?
NO | | 13e. STREET ADDRESS / ZIP CODE
516 A. Philmar Park 19064 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
William Clark | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Ida Harris | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
221/03/7484 | | 17. INFORMANT (Sister)
Anna King | | ADDRESS
106 Sycamore Rd. 21090 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1629 Lung Cancer
IMMEDIATE CAUSE (a) _____
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 months | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 19, 84 to April 25, 19, 84 , that (I) (we) lost
saw the deceased alive on April 27, 19, 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Philip H Konits | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
4/28/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PHILIP H KONITS, M.D. | | | | 22e. ADDRESS
615 HAMMONDS LANE
BALTIMORE, MARYLAND 21225 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | 23b. DATE
May 1, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Locustwood Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Cherry Hill, Camden N.J. | | | |
| 24. FUNERAL DIRECTOR
NAME Dean F. Charlton ADDRESS
Singleton Funeral Home Glen Burnie, Md | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 1 1984 | | | | |
| 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the deceased. Page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification must be completed.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

EST

| | | | | | |
|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| DECEASED NAME (TYPE OR PRINT) | | MONTH DAY YEAR | | 425 AM | |
| JULIA C. SEDICUM | | APRIL 12, 1984 | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. UNDER 1 YEAR | |
| FEMALE | WHITE | SEPT. 03 1895 | 88 | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| MARYLAND | U.S.A. | | ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION
(TYPE OF WORK OR BEST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | | SEAMSTRESS | GARMENT | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | |
| MARYLAND | BALTIMORE | ARBUTUS | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 5508 LINK AVENUE 21227 | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | |
| FRANK WEIBER | | | HANNA HAFMEISTER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | |
| NO | | 215-07-2924 | MRS. LILLIAN HALL 5605 PARK RD. 21225 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4100 Ventricular fibrillation</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
12 hours
12 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2/11/84</u> , 19 <u>84</u> , to <u>2/12</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>2/12/84</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | |
| <u>Gerald Church</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | <u>2/13/84</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | |
| GERALD CHURCH, M.D. | | 8 EVERGREEN ROAD
SEVERNA PARK, MARYLAND 21146 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (CITY OR TOWN) COUNTY STATE | | |
| BURIAL | 4/16/84 | MEADOWRIDGE | DORSEY HOWARD MARYLAND | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE | | |
| AMROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD | | | APR 16 1984 <u>John T. ...</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as injury, shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09197

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
EDWARD P. Selby | | | 2a. DATE OF DEATH MONTH DAY YEAR
4-9-84 | | 2b. HOUR
12:52 AM |
| 3 SEX
male | 4 RACE
Cauc. | 5. DATE OF BIRTH MONTH DAY YEAR
02 16 16 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 YRS. | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Wash. D.C. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL CO. MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Arundel General Hospital | | 12a. USUAL OCCUPATION
(FULL-TIME WORK OR MOST OF WORKING LIFE)
Retired | | 12b. KIND OF BUSINESS OR INDUSTRY
Contravtor |
| 13a. STATE
MD | | | 13b. COUNTY
V.A.A. | 13c. CITY OR TOWN
Annapolis | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John (na) Selby | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Edith (na) Clifford | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
579-10-1061 | | 17. INFORMANT ADDRESS
Florence Selby 170 Island View Dr. Annapolis Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAL ARREST
2500
DUE TO, OR AS A CONSEQUENCE OF (b) ASCLEROSIS
DUE TO, OR AS A CONSEQUENCE OF (c) Stroke
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Carotid Artery | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 80 to now 19 84 , that (I) (we) lost saw the deceased alive on March 1980 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
A. P. | | DEGREE | | 22c. DATE SIGNED
4/9 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert O Biern | | 22e. ADDRESS
51 Franklin St Annapolis Md 21401 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
12 April 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Ft. Lincoln Cemetery | |
| 23d. LOCATION
CITY OR TOWN COUNTY STATE
Brentwood P.G. Md. | | 23e. DATE REC'D. BY REGISTRAR | | 23f. REGISTRAR'S SIGNATURE
Ch. Davidson-Rendall | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Hale's Lanham F.H. 9013 Annapolis Rd. Lanham Md. | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

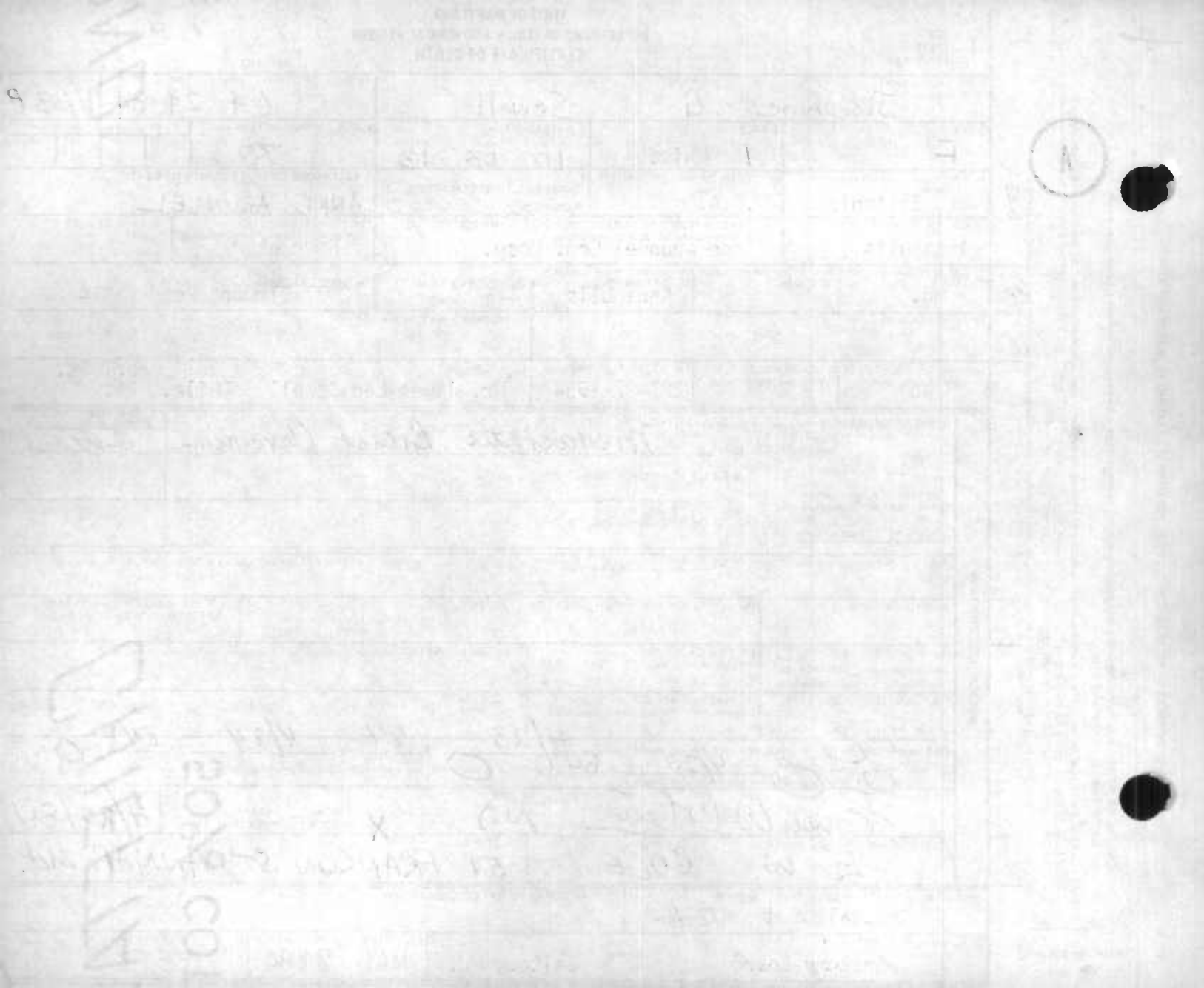
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09198

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Josephine G Sewell | | | 2a. DATE OF DEATH
MONTH 04 DAY 24 YEAR 84 | | | 2b. HOUR
1:03 PM | | | | | |
| 3. SEX
F | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 10 DAY 03 YEAR 13 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | IF UNDER 1 YEAR
MONTHS _____ DAYS _____ | | IF UNDER 24 HRS.
HOURS _____ MIN. _____ | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Illinois | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Gen. Hosp. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE
Md. | | | 13b. COUNTY
Annapolis | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
2017 Elmwood Road 21402 | | |
| 14. FATHER'S NAME
FIRST _____ MIDDLE _____ LAST _____ | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST _____ MIDDLE _____ LAST _____ | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NEVER UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO.
261-07-1554 | | | 17. INFORMANT
ADDRESS 3614 Pearl St. Phila., Pa.
Mr. James Leo Sewell | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Breast Carcinoma
1749
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. _____ MONTH _____ DAY _____ YEAR _____
P.M. _____ 19 _____ | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
4/23 | | 21f. LOCATION
STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____
84 4/24 84 | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/23 19 84 to 4/24 19 84 , that (I) (we) lost
saw the deceased alive on 4/23 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Ernest W. Cole | | | | | | DEGREE MD
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
4/25/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
E W COLE | | | | | | 22e. ADDRESS
51 FRANKLIN ST ANNAP. Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Removal | | | 23b. DATE
4/26/84 | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION
CITY OR TOWN _____ COUNTY _____ STATE _____ | | | |
| 24. FUNERAL DIRECTOR
NAME Anatomy Board ADDRESS Balto., Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR
MAY 2 1984 | | 25b. REGISTRAR'S SIGNATURE
Luka Davidson-Randall | | | |



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09199

REG. NO.

FOR
1 - STATE
REGISTRAR

| | | | | | | | |
|---|--|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Doris M. Sexton | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 14, 1984 | | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
Jan. 10, 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY)
56
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
South Carolina | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH
Laurel | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
8225 Brockbridge Rd. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Assembly line | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Thermolink | | 13a. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13b. STREET ADDRESS / ZIP CODE
8225 Brockbridge Rd. 20707 | | | |
| 13c. CITY OR TOWN
Maryland | | 13d. STATE
Anne Arundel | | 13e. CITY OR TOWN
Laurel | | 13f. STREET ADDRESS / ZIP CODE
8225 Brockbridge Rd. 20707 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Hillard | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Jeroldean Johnson | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No. | | 16b. SOCIAL SECURITY NO.
248-46-2505 | |
| 17. INFORMANT
J.B. Sexton | | ADDRESS
same as #13 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:1809
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Cardiorespiratory Arrest

Advanced and metastatic Cancer of cervix

N/A

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

5 minutes

4 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

N/A

19a. DATE OF OPERATION

N/A

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

N/A

20a. AUTOPSY?

YES ☐ NO ☒20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES ☐ NO ☐21a. ACCIDENT WAS UNDERLYING ☐
OR CONTRIBUTING ☐ CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 1921c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

N/A

21d. INJURY OCCURRED
WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION
STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 5/10/80 to 4/11/84, that (I) (we) last saw the deceased alive on 4/11/84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

Gladys M. Glenn

DEGREE

M.D.

ATTENDING
PHYSICIAN ☐MEDICAL
DIRECTOR ☐STAFF
PHYSICIAN ☒

22c. DATE SIGNED

4/15/84

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

Gladys M. Glenn, M.D.

22e. ADDRESS

Johns Hopkins Oncology Ctr. Baltimore, MD.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

4/18/84

23c. NAME OF CEMETERY OR CREMATORY

Meadowridge Mem. Park Baltimore, Howard, Md.

23d. LOCATION
CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

FLECK FUNERAL HOME, INC. ADDRESS

7601 Sandy Spring Rd. Laurel, Md. 20707

25a. DATE REC'D. BY REGISTRAR

APR 16 1984

25b. REGISTRAR'S SIGNATURE

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

A

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09200

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Mildred Marie Shaeffer | | | 2a. DATE OF DEATH MONTH DAY YEAR April 11, 1984 | | | 2b. HOUR 8:15 P M | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11/8/1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Anne Arundel County MD | | | |
| 10. CITY OR TOWN OF DEATH Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Arundel Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Check Processing | | 12b. KIND OF BUSINESS OR INDUSTRY Bank | |
| 13a. STATE Maryland 13b. COUNTY Anne Arundel 13c. CITY OR TOWN Glen Burnie | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 7473 Furnace Branch Rd Apt A 21061 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clarence C. Shaeffer | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ida Pabletts | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | | | | 16b. SOCIAL SECURITY NO. 214-03-32354 | | 17. INFORMANT ADDRESS Mary E. Wiest - Same as 13e | | | |

| | |
|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure and Arrest
5150
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Severe Pulmonary Fibrosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden
years | |
|--|--|

| | | | |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Chronic Obstructive Lung Disease and angino pectoris. | | | |
|--|--|--|--|

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-11-84 to 4-11-84 , that (I) (we) last saw the deceased alive on 4-11-84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Jack I. Stern | | | | DEGREE | | 22c. DATE SIGNED 4/12/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jack I. Stern M.D. | | | | 22e. ADDRESS 300 Hospital Dr. Suite 135 Glen Burnie MD | | | |

| | | | | | | | |
|--|--|--------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 4/12/84 | | 23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland | |
| 24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc ADDRESS Dundalk MD 21222 | | | | 25a. DATE RECD. BY REGISTRAR APR 13 1984 | | 25b. REGISTRAR'S SIGNATURE K. Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09201

| FOR
STATE
REGISTRAR | | | | REG. NO. | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| JAY Edwin Shanklin | | | | 4-7-84 | | | | 2 ⁰⁰ A.M. | | | |
| 3. SEX | | RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| male | | White | | 1 27 13 | | 71 YRS. | | MONTHS | | DAYS | |
| 7a. BIRTHPLACE
(COUNTY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Nebraska | | U.S.A. | | | | Anne Arundel MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | | | | | 12a. USUAL OCCUPATION
(TYPE AND DUTY FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Annapolis | | Anne Arundel General | | | | | | Attorney | | Law | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? | | | | 13e. STREET ADDRESS / ZIP CODE | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 27 Day Drive 21403 | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| JAY E. C. Shanklin | | | | Myrtle | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR PARTIAL) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| Yes | | | | WWII | | 512034537 Mary M. Shanklin #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY: | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) Sudden death with unsuccessful CPR | | | | | | | | | | | |
| 4960 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (b) | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| Chronic Obstructive Pulmonary Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| George C. Samaras | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 4/7/84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| George C. Samaras | | | | 205 Ridgely Ave Annapolis MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATOR | | 23d. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| Entombment | | | | 4/12/84 | | Oakland | | Moberly MO. | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | |
| Taylor Funeral Chapel Annapolis MD | | | | APR 11 1984 | | | | Julia Davidson-Randall | | | |

11

Handwritten text, mostly illegible due to fading. Some words like "and" and "the" are visible.

Handwritten text, mostly illegible due to fading. Some words like "the" and "and" are visible.

Item 230 Per call from F.H. 4/27/84
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

09202

| | | | | | | | |
|--|--|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| ELIZABETH | | H. SHEEHY | | APRIL 24, 1984 | | 11:37 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS | |
| FEMALE | WHITE | 3 - 14 - 1899 | | 85 YRS. | | MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| MASS. | U.S.A. | | | ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| ANNAPOLIS | 312 SEVERN AVE. APT. # 309 | | | SECRETARY | | BUSINESS | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS / ZIP CODE | | | |
| MD. | A.A. CO. | ANNAPOLIS | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 312 SEVERN AVE 21403 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | |
| PETER PAUL O'BRIEN | | MARY ELLIOTT | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17 INFORMANT ADDRESS | | | |
| NO | | 033-24-5793 | | MR. DONALD J. SHEEHY 311 FOURTH ST. ANNAPOLIS, MD. 21403 | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 1539 IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma of Colon | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNOCCURRED <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | |
| | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 19 83 to 24 April 19 84, that (I) (we) lost saw the deceased alive on 20 April 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not valid, did not see the body after death.) | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| Don B. Lowe MD | | | | 25 April 84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | |
| Don B. Lowe MD | | 77 West St, Suite 210, Annapolis, MD 21401 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 4-30-84 | | NEW CALVARY | | ROSELINDALE MASS | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR? REGISTRAR'S SIGNATURE | | | |
| JOS. GAWLERS' SONS INC. 5130 WISC. AVE. NW. WASH., D.C. | | | | APR 27 1984 Julia Davidson | | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

XXX

122

Handwritten text at the bottom left, possibly a date or reference number: 1933 8.19A.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09203

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
Christian Siegmund SIEGMANN | | | 2a. DATE OF DEATH MONTH DAY YEAR
M 04-10-84 | | 2b. HOUR
2:45A M |
| 3 SEX
male | 4 RACE
cauc. | 5. DATE OF BIRTH MONTH DAY YEAR
2 22 1890 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.
94 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
NEW YORK | 7b. CITIZEN OF WHAT COUNTRY?
USA. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH
Crownsville | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Fairfield Nursing Home | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
CIVIL ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
RET |
| 13a. STATE
MD. | | | 13b. COUNTY
AA | 13c. CITY OR TOWN
Crownsville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
CHRISTIAN SIEGMANN | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
FAIRFIELD Loop Rd. 21032 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
095 28 0863 | | 17. INFORMANT ADDRESS
Mary EDNA SIEGMANN 700 WHITEHALL PHAUNS RD. 21401 | |

| | | |
|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4409 IMMEDIATE CAUSE (a) Uremia | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
one year |
| DUE TO, OR AS A CONSEQUENCE OF
(b) generalized atherosclerosis | | many years |
| DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | _____ |

| | | | |
|---|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
none | | | |
| 19a. DATE OF OPERATION
N/A | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) the deceased attended the deceased from November 16, 1981, to April 9, 1984, that (I) (we) last saw the deceased alive on March 9, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Charles W. Kinzer | | 22c. DATE SIGNED
April 10, 1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Charles W. Kinzer, M.D. | | 22e. ADDRESS
16 Murray Avenue, Annapolis, Maryland 21401 | |

| | | | |
|---|----------------------|--|---|
| 23a. BURIAL, CREMATION/REMOVAL
(SPECIFY)
CREMATION | 23b. DATE
4/11/84 | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR HILL | 23d. LOCATION
CITY OR TOWN COUNTY
SOUTHAWD P.G. MD. |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Taylor Funeral Chapel Annapolis, MD | | 25a. DATE REC'D. BY REGISTRAR
APR 11 1984 | |
| 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

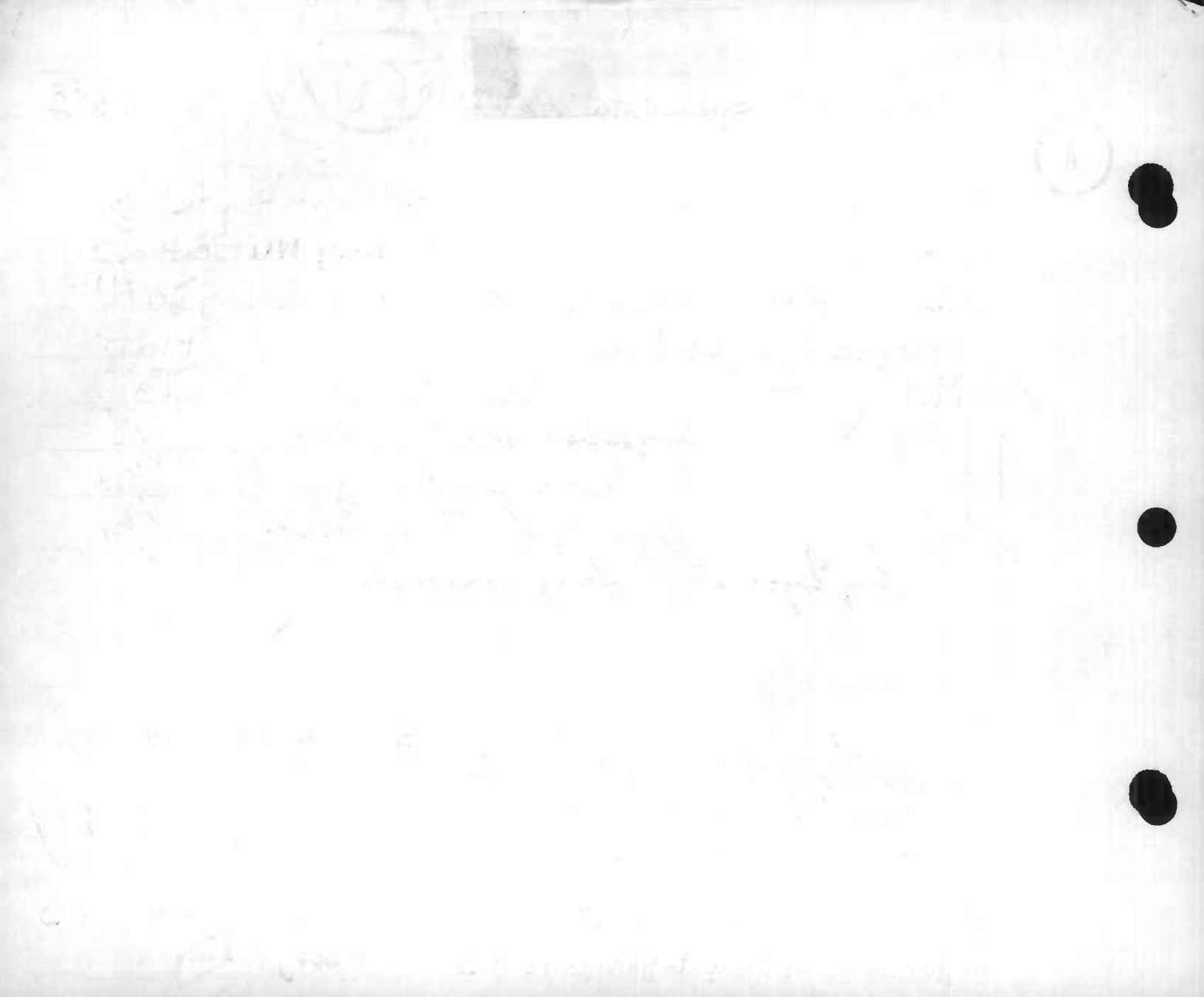
0-9 2 0 4

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | |
|---|--|---|---|--|--|--|--|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Smith, Anna Augusta Anna | | | 2a. DATE OF DEATH MONTH DAY YEAR
4 24 84 | | | 2b. HOUR
6 08 AM | | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
8 25 08 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75 YRS. | | 7. IF UNDER 1 YEAR IF UNDER 24 HRS.
MONTHS DAYS HOURS MIN. | | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 9. CITIZEN OF WHAT COUNTRY?
USA | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | | | | |
| 12. CITY OR TOWN OF DEATH
Annapolis | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | | | 14. USUAL OCCUPATION
(PE OF WORK FOR MOST OF WORKING LIFE)
Nurse Hospital | | 15. KIND OF BUSINESS OR INDUSTRY | | |
| 16. USUAL RESIDENCE (IF RESIDING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
16a. STATE MD 16b. COUNTY AN. Co. | | 17. CITY OR TOWN
Annapolis | | 18. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 19. STREET ADDRESS / ZIP CODE
11201 Sterling Drive 211403 | | | | |
| 20. FATHER'S NAME
FIRST MIDDLE LAST
George Blieve | | 21. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Bertha Platt | | 22. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | 23. SOCIAL SECURITY NO. | | 24. INFORMANT ADDRESS
Clara J. Caylor - Same as #13 | | |
| 25. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Heart Failure
4148
DUE TO, OR AS A CONSEQUENCE OF:
(b) Ischemic cardiomyopathy
(c) Coronary atherosclerosis
CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
yes
yes
yes | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
Emphysema Lung cancer | | | | | | | | | | |
| 26. DATE OF OPERATION | | | 27. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 28. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 29. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 30. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 31. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 32. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) | | | | |
| 33. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 34. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 35. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | |
| 36. I certify that (I) (this hospital) attended the deceased from 4/23 19 84 , to 4/24 19 84 , that (I) (we) last saw the deceased alive on 4/23 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 37. SIGNATURE
Joseph N. Friend M.D. | | | | | | 38. DEGREE
M.D. | | 39. DATE SIGNED
4/24/84 | | |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT)
Joseph N. Friend | | | | | | 41. ADDRESS
205 Ridgely Ave. Annapolis, MD | | | | |
| 42. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 43. DATE
Apr. 27, 1984 | | | 44. NAME OF CEMETERY OR CREMATORY
St. Anne's | | | 45. LOCATION
CITY OR TOWN COUNTY STATE
Annapolis AN. MD | |
| 46. FUNERAL DIRECTOR
NAME
Taylor Funeral Chapel - Annapolis, MD | | | | | | 47. DATE REC'D. BY REGISTRAR
APR 26 1984 | | 48. REGISTRAR'S SIGNATURE
Chia Davidson | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

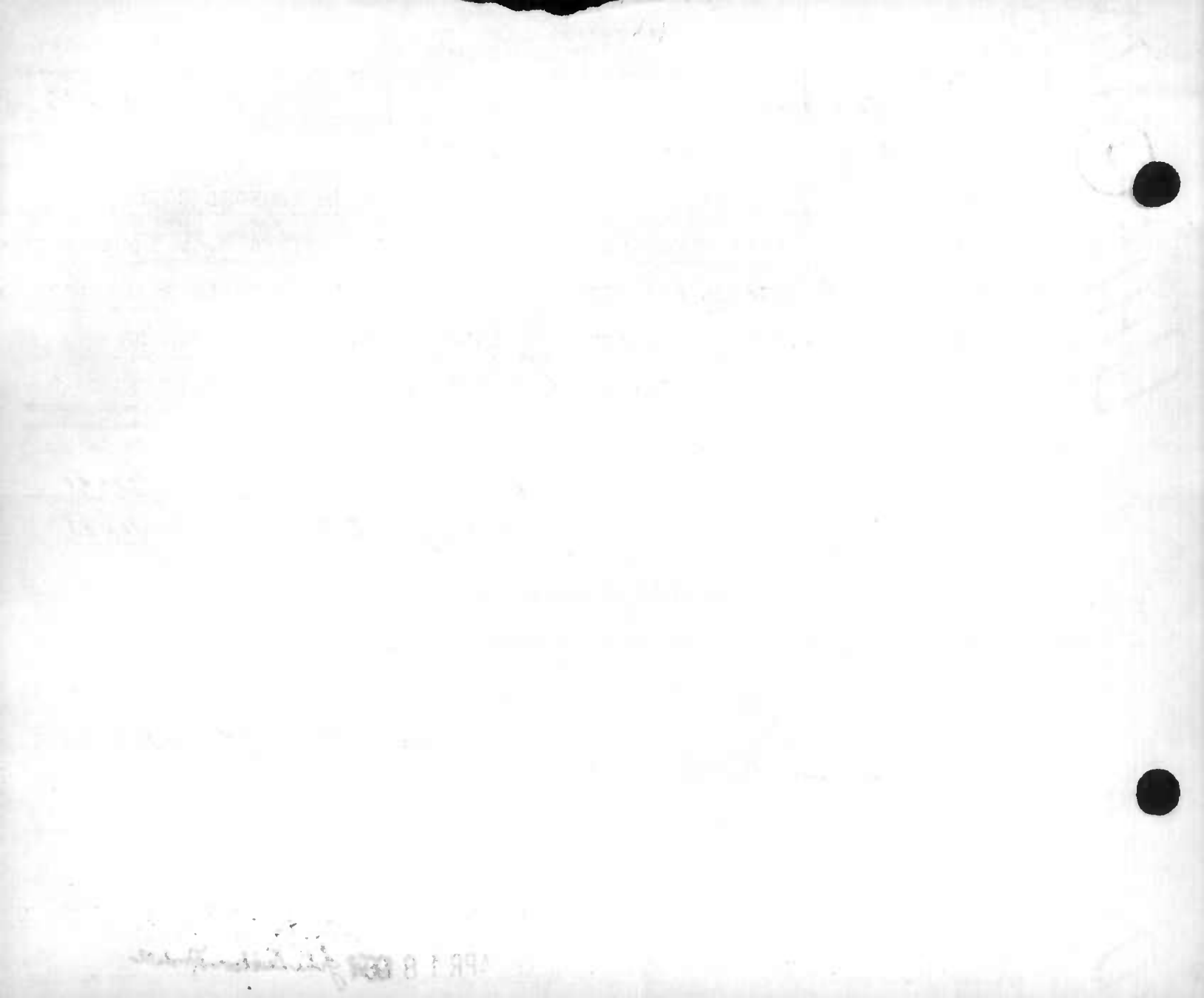
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09205

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--|--|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) CLAIRBORNE R SMITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4-5-84 | | | 2b. HOUR
MIN.
11 40 A | | | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH DAY YEAR
NOV. 11, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS.
82 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
0 0 | | 8. IF UNDER 24 HRS.
HOURS MIN.
0 0 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
VIRGINIA | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
EDGEWATER | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1541 MAYFIELD ROAD | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
BUS DRIVER D.C. | | | 12b. KIND OF BUSINESS OR INDUSTRY
TRANSIT CO. | | |
| 13a. STATE
MARYLAND | | | | | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
EDGEWATER | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES H. SMITH | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LOLA E. EDWARDS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
578-10-7376 | | 17. INFORMANT
ADDRESS
ALMEDA B. SMITH SAME AS 13 E | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Arrest
4960
DUE TO, OR AS A CONSEQUENCE OF
(b) COPD
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Prostatic EA | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
years
years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from before , 19 83 , to 4/5 , 19 84 , that (I) (we) last saw the deceased alive on March April , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Jack Teitelbaum | | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)
JACK TEITELBAUM | | | | | | 22c. ADDRESS | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
4-7-84 | | 23c. NAME OF CEMETERY OR CREMATORY
FORT LINCOLN CEMETERY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
BRENTWOOD PRINCE GEORGES | | | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT E. EVANS ANNAPOLIS, MARYLAND | | | | | | 25a. DATE RECEIVED BY REGISTRAR
APR 18 1984 | | | | | |

BP.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09206

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) JAMES F. SMITH | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 3, 1984 | | | 2b. HOUR
10²⁸ AM | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 3 1983 | | 6. AGE (IN YEARS LAST BIRTHDAY)
1 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | | | 22a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
NONE | | 12b. KIND OF BUSINESS OR INDUSTRY
NONE | |
| 13a. STATE
Maryland | | | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Arnold | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Geoffrey L. Smith | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Kathleen A. Reid | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
--- | | 17. INFORMANT
ADDRESS
Geoffrey L. Smith (SAME AS 13) | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary Arrest**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

DUE TO, OR AS A CONSEQUENCE OF

(c) **Severe Bronchopulmonary Dysplasia**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

Extreme Prematurity, Bilateral Renal Calculi

| | | | | | | | |
|--|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from July 1983 to April 3, 1984 , that (I) (we) last saw the deceased alive on April 3, 1984 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Lillian R. Blackmon | | | | DEGREE
M.D. | | 22c. DATE SIGNED
April 13, 1984 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Lillian R. Blackmon | | | | 22e. ADDRESS
Dept. Pediatrics, University Md. Hospital | | | |

| | | | | | | | |
|--|--|-----------------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
APRIL 6, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GLEN BURNIE ANNE ARUNDEL MD | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT S. BARRANCE | | | | DATE RECEIVED BY REGISTRAR
APR 9 1984 | | | |

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APR 2 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be buried with the deceased 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner, relative to the death, must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 09207 | | | |
|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
SMITH, M. LORETTA | | | | 2a. DATE OF DEATH MONTH DAY YEAR
APRIL 15, 1984 | | | |
| 3. SEX
Female | | | | 2b. HOUR
04 20 PM | | | |
| 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
Jan. 25, 1900 | | 6. AGE (IN YEARS LAST BIRTHDAY)
84 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
CLLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
at home | |
| 13a. STATE
Maryland | | 13b. COUNTY
A.A.Co. | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Samuel ----- High | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Margaret ----- Gill | | 13e. STREET ADDRESS / ZIP CODE
1660 Connfield Rd. Pasadena, Md. 21122 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NOT UNKNOWN) (IF YES, GIVE WAR OR DATES)
No | | 16b. SOCIAL SECURITY NO.
219-40-4131 | | 17. INFORMANT ADDRESS
Mr. Vernon Frame, 3111 Mountain Rd. Pasadena, Md. 21122 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5140 Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Acute Pulmonary Edema
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-14-84 to 4-15-84, that (I) (we) lost saw the deceased alive on 4-15-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
S. L. M. M.D. | | DEGREE
M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4-15-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. CHACKUMMAL, CYRIAC | | 22e. ADDRESS
14 WELLMAN AVENUE SUITE 101 CLLEN BURNIE MARYLAND 21061 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
April, 20, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Loudon Park Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Baltimore, Maryland | |
| 24. FUNERAL DIRECTOR NAME
McCutty Funeral Home, Mt. & Tickneck Rds. Pasadena | | 25a. DATE REC'D. BY REGISTRAR
APR 23 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | | | |

1876



Handwritten signature or text, possibly "The Young Man"

Handwritten text at the bottom of the page, including "The Young Man" and other illegible words.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09208

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) WILLIAM M. SMITH | | | 2a. DATE OF DEATH
MONTH 4 DAY 17 YEAR 84 | | | 2b. HOUR
6:14 PM | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH 7 DAY 17 YEAR 22 | | 6. AGE (IN YEARS LAST BIRTHDAY)
61 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
North Arundel Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Tool Engineer | | | |
| 12b. KIND OF BUSINESS OR INDUSTRY
Koppens Co. | | | | | | | | | |
| 13a. STATE
Md | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Pasadena | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET ADDRESS
142 Sandy Beach Dr. 21122 | | | | | | | | | |
| 14. FATHER'S NAME
FIRST Earl MIDDLE D. LAST Smith | | | 15. MOTHER'S MAIDEN NAME
FIRST Louise MIDDLE V. LAST Immler | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO.
214-12-9661 | | 17. INFORMANT
Evelyn V. Smith | | | | | |
| 16c. ADDRESS
Same as 13e | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4100 Myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 hours | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
none | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/8 , 19 79 , to 4/17 , 19 84 , that (I) (we) last saw the deceased alive on 3/10 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
R. M. McLaughlin, M.D. | | | DEGREE
M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL STAFF
DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/17/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS
3708 Mountain Rd. Pasadena, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
4/20/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Crestlawn Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Sykesville Carroll Md | | |
| 24. FUNERAL DIRECTOR
George J. Gonce | | | ADDRESS
4001 Ritchie Hwy | | | 25a. DATE REC'D. BY REGISTRAR
APR 23 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 1 hour after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09209

1- FOR
STATE
REGISTRAR

REG. NO.

EST

| | | | | | | | | | | |
|---|--|---|--|---|--|--|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
CORNELIUS CLARENCE SOBOTTA | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 20 1984 | | | 2b. HOUR
0532 AM | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 MONTH 11 DAY 1917 | | 6. AGE
(IN YEARS LAST BIRTHDAY)
66 | | 7. UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
Wisconsin | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Major | | 12b. KIND OF BUSINESS OR INDUSTRY
US Army | | |
| 13a. STATE
Md | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Millersville | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1704 Baldwin Dr. 21108 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank Sobotta | | | 15. MOTHER'S MAIDEN NAME
MIDDLE LAST
Kathryn Swietz | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES OR UNKNOWN)
Yes | | | 16b. SOCIAL SECURITY NO.
(IF IN U.S. WORKING STATES)
1934-1980 394-03-7671 | | 17. INFORMANT
ADDRESS
Doris Sobotta # 13 | | | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):

Diabetes Mellitus; HBP

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH1 hour
8 hrs.

MEDICAL CERTIFICATION

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended and deceased from 8 PM, 19 83, to 15 Mar 19 84, that (I) (we) last saw the deceased alive on 15 Mar 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SKINATURE
James King M.D. | | | | 22c. DATE SIGNED
20 Apr. 84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. JAMES KING | | | | 22e. ADDRESS
KIMBOROUGH ARMY HOSPITAL
FORT MEADE, MARYLAND | | | |

| | | | | | | | |
|---|--|----------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
4-24-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Our Lady of the Fields | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Millersville A.A. Md | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
T. A. Hardesty Annapolis Maryland 21401 | | | | 25a. DATE REC'D. BY REGISTRAR
APR 25 1984 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT

CHICAGO, ILL.

TO THE UNIVERSITY OF CHICAGO

FROM THE PHYSICS DEPARTMENT

CHICAGO, ILL.

1922

1922

1922

x

1922

THE UNIVERSITY OF CHICAGO
PHYSICS DEPARTMENT

CHICAGO, ILL.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 09210 | |
|---|--|--|--|---|--|---|--|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME
(TYPE OR PRINT) Ruth M Stauffer | | | | | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 3. SEX Female | | | | | | 4. RACE white | | 5. DATE OF BIRTH
MONTH DAY YEAR
MAY 25 1908 | | 6. AGE (IN YEARS LAST BIRTHDAY)
75
YRS MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY) PA. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
A.A. MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel Gen. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Waitress | | 12b. KIND OF BUSINESS OR INDUSTRY
Restaurant | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
STATE PA. COUNTY Clearfield CITY OR TOWN DuBoise | | | | | | 13b. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS / ZIP CODE
102 South Jared Dr 15801 | | | |
| 14. FATHER'S NAME
FIRST Leon G. MIDDLE Nickerson LAST Edith | | | | 15. MOTHER'S MAIDEN NAME
FIRST Edith MIDDLE Wilson LAST Wilson | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) | | | |
| 16b. SOCIAL SECURITY NO.
176-10-2321 | | | | 17. INFORMANT
W.G. Stauffer, Sr. | | | | ADDRESS 150 Autumn Ct, Huntingtown, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
1029 IMMEDIATE CAUSE (a) metastatic lung CA
DUE TO, OR AS A CONSEQUENCE OF (b) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: severe euphoria | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 3/30 19 84 , to 4/6 19 84 , that (I) (we) lost saw the deceased alive on 4/6 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Stuart E. Selonick, M.D. | | | | DEGREE M.D. | | | | 22c. DATE SIGNED
4/6/84 | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Stuart E. Selonick, M.D. | | | | 22e. ADDRESS
51 Franklin St. Annapolis Md 21401 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE | | | | | |
| Cremation | | 4/7/84 | | Cedar Hill Cemetery | | Suitland P.B. MD | | | | | |
| 24. FUNERAL DIRECTOR
NAME Taylor Funeral Chapel ADDRESS Annapolis, MD | | | | 25a. DATE RECD. BY REGISTRAR
APR 11 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09211

REG. NO.

| | | | | | |
|--|--|--|--|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Frida Emilia Strobl | | 2a. DATE OF DEATH MONTH DAY YEAR APR. 5-84 | | 2b. HOUR 3:35 PM | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR JAN 4 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GERMANY | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH A. A. COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH SEVERN PARK | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MERIDIAN SEVERN PARK | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home |

| | | | | | | | |
|---|--|---|--|------------------------------------|--------------------------------------|--|--|
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13a. STATE Maryland | | 13b. COUNTY A.A. | 13c. CITY OR TOWN Glen Burnie | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE 7643 Marcy Court 21061 |
| 14. FATHER'S NAME FIRST MIDDLE LAST Friedrich Arning | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emilia Sauermann | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 215.03.1105 | | 17. INFORMANT Granddaughter | | 17. NAME Susan A. Dolle | |
| | | | | | | 17. ADDRESS Same as 13 | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) congestive heart failure | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4280
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | |
| (b) _____
DUE TO, OR AS A CONSEQUENCE OF | | | |
| (c) _____ | | | |

| | | | |
|--|--|---|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: diabetes | | | |
| 19a. DATE OF OPERATION — | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> N/A NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) N/A | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT AT WORK <input checked="" type="checkbox"/> AT WORK N/A | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) N/A | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE N/A | |

| | | | | |
|--|--|--|--|-------------------------------------|
| 22a. I certify that (I) (this hospital) attended the deceased from 1-26 19 84 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | 22b. SIGNATURE Thomas Walsh MD DEGREE MD | | 22c. DATE SIGNED Apr 6, 1984 |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS WALSH MD | | 22e. ADDRESS 269 Peninsula Farm Road | | |

| | | | |
|---|----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE Apr 9, 84 | 23c. NAME OF CEMETERY OR CREMATORY Moreland Mem Park | 23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balto MD |
| 24. FUNERAL DIRECTOR NAME H B Unnam ADDRESS Singleton Funeral Home, Glen Burnie, MD | | 25a. DATE REC'D. BY REGISTRAR APR 10 1984 REGISTRAR'S SIGNATURE J. Davidson-Rendell | |

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09212

FOR
1- STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|---|---|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FREDERICK F. STUTZ | | | 2a. DATE OF DEATH MONTH DAY YEAR
4-25-84 | | | 2b. HOUR
2 A.M. | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR
7-21-15 | | 6. AGE (IN YEARS LAST BIRTHDAY)
68 | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
PA. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
A.A. Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
SEVERNA Pk | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
1077 OLD COUNTY RD. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
MAINTENANCE | | 12b. KIND OF BUSINESS OR INDUSTRY
TIRE Co. | |
| 13a. STATE
PA | | 13b. COUNTY
MONTEGUTY | | 13c. CITY OR TOWN
ROSETOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
1431 MAPLE ST. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
66W STUTZ | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
MARY JANE WOODS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) YES | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WHAT OFFICE) 179059845 | | 17. INFORMANT ADDRESS
KATHLEEN STUTZ - WIFE SEC. 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
1579 IMMEDIATE CAUSE (a) Metastatic Pancreatic Carcinoma | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 mo. | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | (b) _____ | |
| | | | | | | | | (c) _____ | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)
Inanition | | | | | | | | | |
| 19a. DATE OF OPERATION
3/29/84 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Pancreatic Carcinoma | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from March 29, 1984 , to April 18, 1984 , that (I/we) last saw the deceased alive on April 18, 1984 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I/we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Eric A. Wierke | | | | | | DEGREE
MD | | 22c. DATE SIGNED
4/25/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
ERIC A. WIERKE | | | | | | 22e. ADDRESS
JOHNS HOPKINS HOSP. BALT. MD | | | |
| 23a. BURIAL CREMATION, REMOVAL (SPECIFY)
BURIAL | | | 23b. DATE
4/28/84 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. ALOYSIUS NEW | | 23d. LOCATION CITY OR TOWN COUNTY STATE
ROSETOWN Mont. PA. | | |
| 24. FUNERAL DIRECTOR (NAME)
Edna Bananco Severna Pk | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 27 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

Handwritten notes and calculations, including the number 121 and various symbols.

DELIVER IN
100% COTTON

Handwritten text at the bottom of the page, possibly a signature or date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09213

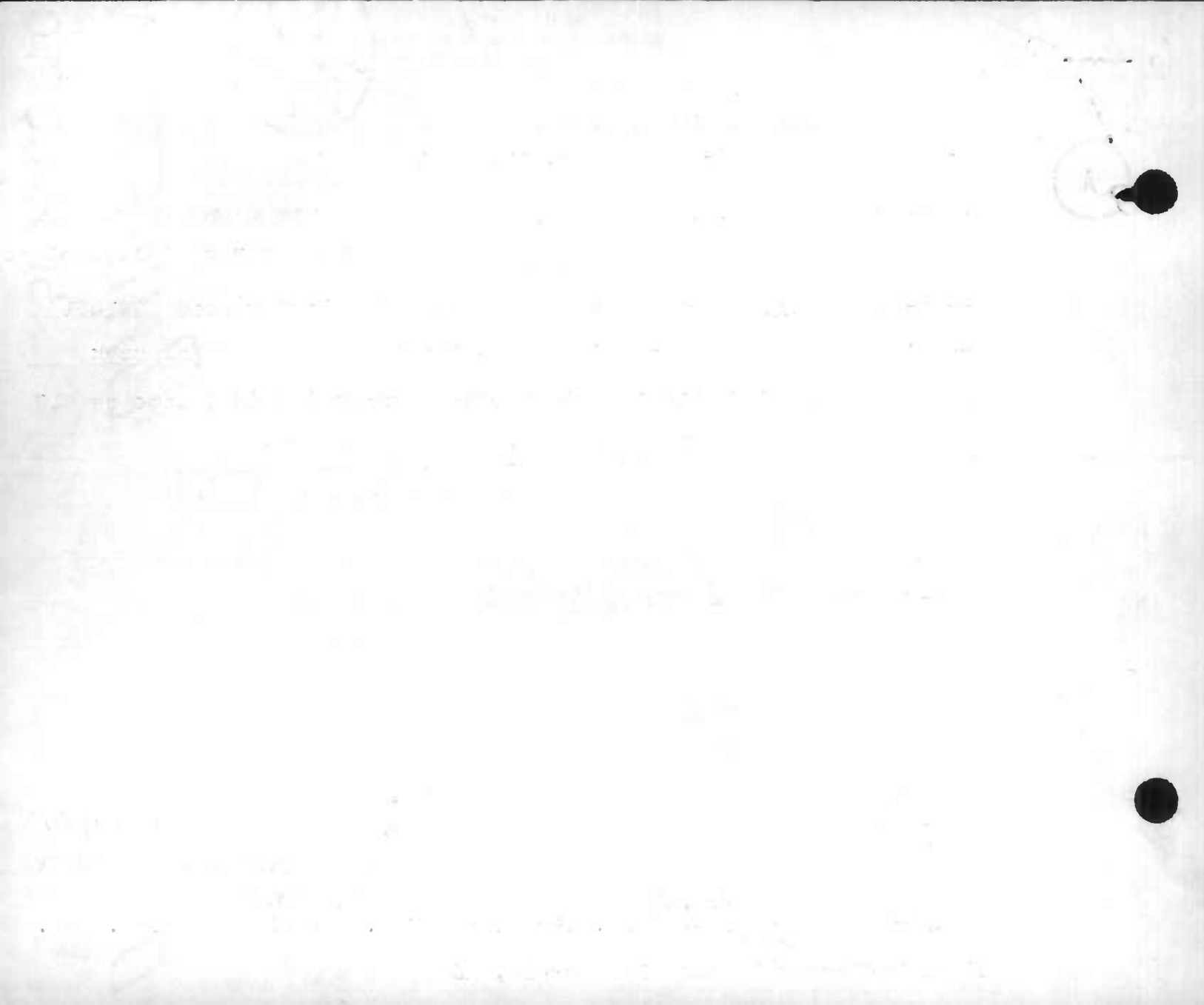
1- FOR
STATE
REGISTRAR

REG. NO.

EST

| | | | | | |
|--|--|---|---|--|---|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
NORMAN ALFRED SZYMANSKI | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 14, 1984 | | 2b. HOUR
0100 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
Nov. 17, 1923 | 6. AGE (IN YEARS LAST BIRTHDAY)
60 YRS. | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN.
IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE
(COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Truck Driver | | 12b. KIND OF BUSINESS OR INDUSTRY
Self Employed |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | |
| 13a. STATE
Maryland | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
620 Baylor Road 21061 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Francis Szymanski | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Pearl Kasprzyk | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
218/18/8932 | 17. INFORMANT
ADDRESS
Stella Szymanski (Wife) Same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory arrest
4280
DUE TO, OR AS A CONSEQUENCE OF
(b) Severe congestive heart failure
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Chronic chest lung disease | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost
saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
[Signature] DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/>
PHYSICIAN DIRECTOR PHYSICIAN | | | | 22c. DATE SIGNED
4/14/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
[Name] | | | 22e. ADDRESS
7422 BALTIMORE ANNAPOLIS BOULEVAR | | |
| 23a. BURIAL, CREMATION, REMOVAL, OR OTHER DISPOSITION
(SPECIFY)
Burial | | 23b. DATE OF BURIAL, CREMATION, REMOVAL, OR OTHER DISPOSITION
April 17, 1984 | | 23c. NAME OF CEMETERY OR CREMATOR
St. Stanislaus Cem. Dundalk | |
| 23d. CITY OR TOWN
Balto. | | 23e. COUNTY
Md. | | 23f. STATE
Md. | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home Glen Burnie, Md | | | 25a. DATE REC'D. BY REGISTRAR
APR 17 1984 | | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | 25c. REGISTRAR'S NAME
[Name] | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09214

1 - FOR
STATE
REGISTRAR

REG. NO.

EDT

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
HOWARD Thomas TALBOT | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 30, 1984 | | 2b. HOUR
920 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
April 25, 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
California | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Supervisor | | 12b. KIND OF BUSINESS OR INDUSTRY
General Mtrs |
| 13a. STATE
Maryland | | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Glen Burnie | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Grover Cleveland Talbot | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mabel Hayes | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W.II | | 17. INFORMANT (Son-Inlaw) ADDRESS
529 Annabel Ave. Mr. Louis Plucinski Baltimore, Md 21225 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (b) post-surgery
DUE TO, OR AS A CONSEQUENCE OF (c) 4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost
saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Frank A. Faraino | | DEGREE
FRANK A. FARAINO, M.D. | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS
1205 YORK ROAD, SUITE 38 LUTHERVILLE, MARYLAND 21093 | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. NAME OF CEMETERY OR CREMATORY
Baltimore Natl. Cem. | | 23c. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore City Md. | |
| 24. FUNERAL DIRECTOR
NAME
Dean P. Charlton | | ADDRESS
Singleton Funeral Home Glen Burnie, Md | | 25a. DATE REC'D. BY REGISTRAR
MAY 3 1984 | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

YOUNG BROTHERS CO.

AMERICAN BROTHERS CO.

AMERICAN BROTHERS CO.

AT THE BACK OF THE
BOOKS OF THE AMERICAN BROTHERS CO.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09215

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
MADLINE C TAYLOR | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 8 84 | | | 2b. HOUR
620 P.M. | | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
11 23 03 | | 6. AGE (IN YEARS LAST BIRTHDAY)
80 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANN ARUNDEL MD. | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
A. H. GEN. HOSP. | | | | 12. USUAL OCCUPATION
(TYPE OR PRINT; IF FOR CODE, GIVE CODE FIRST)
CAFETERIA | | 13. KIND OF BUSINESS OR INDUSTRY
SCHOOL | |
| 13a. STATE
MD | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
ANNAPOLIS | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
215 Cape St John 21401 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
WILLIAM G. LUCAS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CORA HUNT | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | | | |
| 16b. SOCIAL SECURITY NO.
21732 8430 | | 17. INFORMANT
MARY DOROTHY WHITE #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 10 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | STATE |
| 22a. I certify that on this hospital attended the deceased from 19 79 to 8 April 1984 that (1) (see) first saw the deceased alive on 7 April 1984 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) see the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Hon. B. Howe | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED
8 April 84 | | | |
| 22d. PHYSICIAN'S NAME (LAST OR FIRST)
Hon. B. Howe | | | 22e. ADDRESS
77 West St. Annapolis MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
5/12/84 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR BLUFF | | 23d. LOCATION
CITY OR TOWN COUNTY
ANNAPOLIS AA MD | | |
| 24. FUNERAL DIRECTOR
NAME
TAYLOR FUNERAL CHAPEL | | | ADDRESS
ANNAPOLIS MD. | | 25a. DATE REC'D. BY REGISTRAR
APR 11 1984 | | 25b. REGISTRAR'S SIGNATURE
Davidson-Hardell | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director on page 3, should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 09216 | | | |
|---|--|--|--|---|--|---|--|--|--|---|--|---------------|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE OF DEATH
MONTH DAY YEAR | | | | 2b. HOUR
M | |
| Mary | | Ralich | | THOMAS | | April 16, 1984 | | | | M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
June 6, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY)
51 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Pennsylvania | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Severn | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
759 Pine Road | | | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Severn | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
759 Pine Road 21144 | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Mane Ralich | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Sophie Dimitrovich | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)
No None | | 16b. SOCIAL SECURITY NO.
162.30.0169 | | 17. INFORMANT
Daughter
Kathleen T. Baskett | | ADDRESS
Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) carcinoma of lung, metastatic
1629
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 years | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (this hospital) attended the deceased from 19 82, to April 16, 19 84, that (I) (we) lost
saw the deceased alive on March 23, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Michael B. Stewart, M.D. | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
Apr 17, 84 | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL B. STEWART, M.D. | | 22e. ADDRESS
University of Maryland Cancer Center
23 So. Greene St., Balto., Md. 21201 | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
April 20, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Sylvania Hills Cem. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Rochester Beaver Pa. | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home Glen Burnie, Md | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR
APR 19 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | | | |

STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

09217

 FOR
 STATE
 REGISTRAR

REG. NO.

| | | | | | | | |
|--|--|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
MARY A. E. TUBBS | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4 11 84 | | | 2b. HOUR
7 ¹⁰ A.M. | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 16 91 | | 6. AGE (IN YEARS LAST BIRTHDAY)
92 YRS. | |
| 7a. BIRTHPLACE
(STATE OR FOREIGN)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL MD. | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN HOME FACILITY, GIVE STREET ADDRESS)
H.A. GEN. HOSP. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOUSEWIFE | |
| 12b. KIND OF BUSINESS OR INDUSTRY
HOME | | 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE 13b. COUNTY 13c. CITY OR TOWN
MD A.A. ANNAPOLIS | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
CHARLES F. EVANS | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
LAURA V. JOHNSON | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) NO | | | |
| 16b. SOCIAL SECURITY NO.
058186815 | | 17. INFORMANT
ADDRESS
FREDERICK EVANS 1601 SEXTON ST. BALTIMORE MD 21230 | | | | | |

 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
 PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

 4409
 Conditions, if any, which
 gave rise to immediate
 cause (a), stating the
 underlying cause last.

 (b) Aspiration Pneumonia
 (c) Hemiparesis
 (d) Myocardial Infarction
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

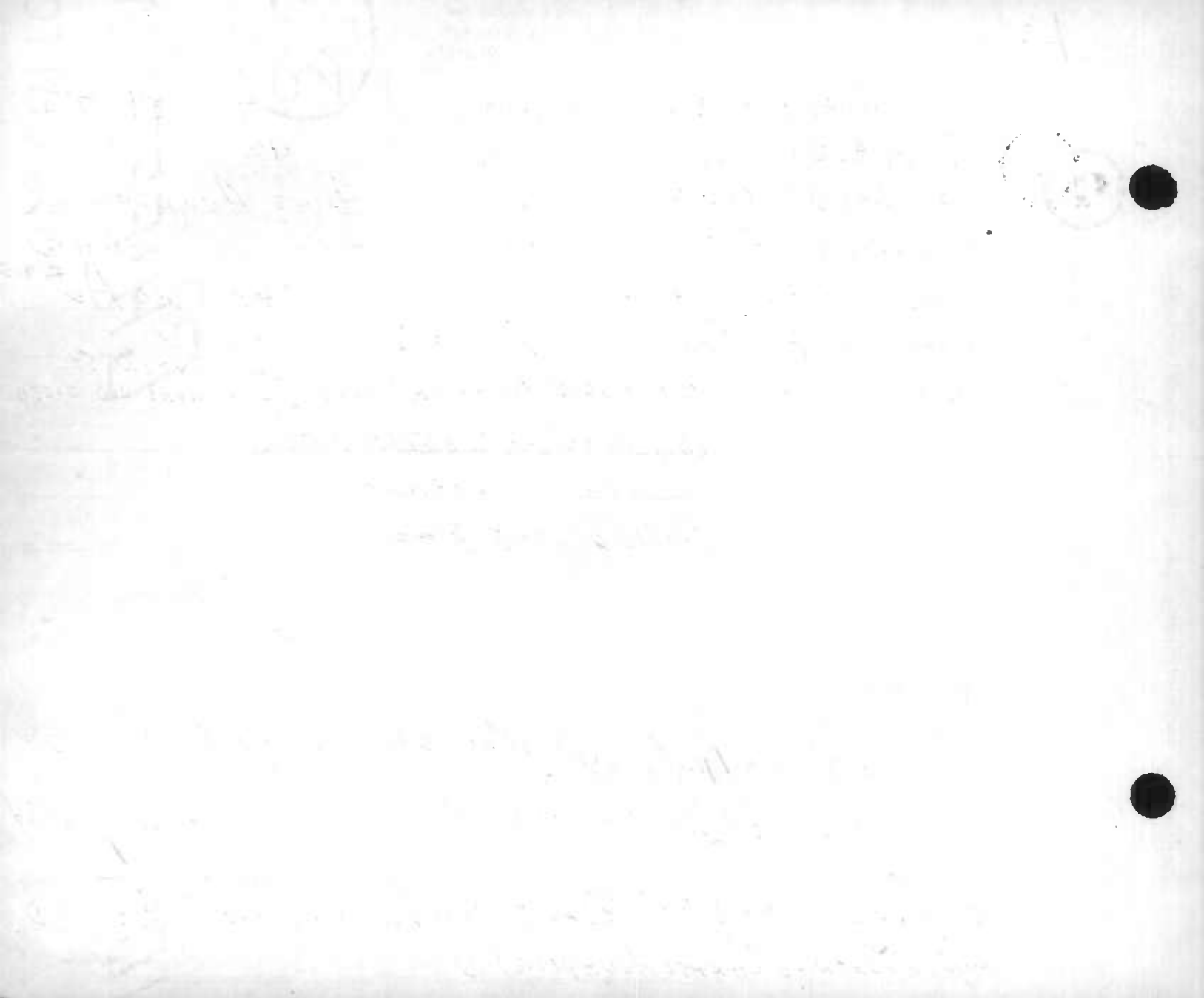
| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Mon, 1984</u> to <u>11 April 1984</u> , that (I) (we) last saw the deceased alive on <u>11 April 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
JON HOWE | | DEGREE
DECEASED | | 22c. DATE SIGNED
11 April 84 | | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JON HOWE | |
| 22e. ADDRESS
West St. Annapolis MD. | | 22f. ADDRESS
West St. Annapolis MD. | | 22g. ADDRESS
West St. Annapolis MD. | | | |

| | | | | | | | |
|--|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(TYPE OR PRINT)
BURIAL | | 23b. DATE
4-13-84 | | 23c. NAME OF CEMETERY OR CREMATORY
CEDAR BLUFF CEM. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
ANNAPOLIS A.A. MD | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Taylor Funeral Chapel Annapolis MD | | | | 25a. DATE REC'D. BY REGISTRAR
APR 18 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (page 3) should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09218

FOR
1- STATE
REGISTRAR

REG. NO.

EST

| | | | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
LULA MAY ULMER | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 13, 1984 | | | 2b. HOUR
703 PM | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
9 16 06 | | 6. AGE (IN YEARS LAST BIRTHDAY)
77 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Md | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY
Home Maker | | | |
| 13a. STATE
Md | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Riviera Bch | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
8538 Main Avenue 21122 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Thomas Clayland | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lula M. Armacost | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
219-16-6167 | | 17. INFORMANT
ADDRESS
Mary Lou Myers Same as 13e | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal Aneurysm Rupture
4413
DUE TO, OR AS A CONSEQUENCE OF
(b) atherosclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
hrs
6 yrs | | | |
| | | | | | | | | | | | |
| | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):
Severe Chronic Obstructive Pulmonary Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/21 , 19 80 , to 3/05 , 19 84 , that (I) (we) lost
saw the deceased alive on 2/05 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (and) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Michael J. Gonce
22b. PHYSICIAN'S NAME (TYPE OR PRINT)
MICHAEL F. GONCE, M.D. | | | | | 22c. DATE SIGNED
4/16/84 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | | | | 23b. DATE
4/16/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem Pk | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Glen Burnie A.A. Md | | |
| 24. FUNERAL DIRECTOR
George J. Gonce 4001 Ritchie Hgwy Balto Md | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 17 1984 | | | | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09219

EST

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|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | EST | |
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ALEXANDER VANCE | | | 2a. DATE OF DEATH MONTH DAY YEAR
APRIL 6, 1984 | | 2b. HOUR
625 PM |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH MONTH DAY YEAR
Mar. 21, 1898 | 6. AGE (IN YEARS LAST BIRTHDAY)
86 YRS. | | IF UNDER 1 YEAR MONTHS DAYS
IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Printer | | 12b. KIND OF BUSINESS OR INDUSTRY
Harline Bros. |
| 13a. STATE
Maryland | | | 13b. COUNTY
Anne Arundel | 13c. CITY OR TOWN
Baltimore | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME FIRST MIDDLE LAST
John Vance | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Elizabeth Chestnut | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
1 217-01-9555 | 17. INFORMANT ADDRESS
Olive A. Vance Same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4100
DUE TO, OR AS A CONSEQUENCE OF White Coronary Atherosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) ASEVD
DUE TO, OR AS A CONSEQUENCE OF
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Rept. venous | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
<input type="checkbox"/> | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did and did not view the body after death. | | | | | |
| 22b. SIGNATURE
Blmo M. Gayoso | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
BLMO M. GAYOSO, M.D. | | 22e. ADDRESS
273-F PENINSULA FARM ROAD ARNOLD, MARYLAND 21012 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/10/1984 | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Balto., A. A. Co., Md. |
| 24. FUNERAL DIRECTOR NAME
McCurly Funeral Homes | | 24a. ADDRESS
Balto., Md., 21225 237 E. Patapsco Ave., | | 24b. DATE REC'D. BY REGISTRAR
APR 12 1984 | |
| | | | | 24c. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Possession by the retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, the possessor should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP _____

DHMH - 16 50M 1/81
(VRA 15, 4)

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|---|--|---|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 09220 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Elise C. VAN STEENBERGH | | | | | 2a. DATE OF DEATH MONTH DAY YEAR HOUR 4 3 84 4:40 M | | | | |
| 3. SEX Female | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Oct 6, 1901 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Annapolis MD. | | | |
| 10. CITY OR TOWN OF DEATH Crofton | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Crofton Convalescent Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 13a. STATE MD | | 13b. COUNTY AA | | 13c. CITY OR TOWN Crownsville | | 13e. STREET ADDRESS Fairfield Loop Rd. 21032 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Calhoun | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine Lindenhol | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. 152-03-8742 | | 17. INFORMANT JOAN CALHOUN 8555 AVE SEA GIRT, N.J. 08750 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST
DUE TO, OR AS A CONSEQUENCE OF (b) CONGESTIVE HEART FAILURE
DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC CARDIO-VASCULAR D
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 2 WKS YEARS | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) this hospital attended the deceased from March 19 82 , to April 3 19 84 , that (1) (we) last saw the deceased alive on APRIL 3 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE BARRY R. NATHANSON MD | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 4/4/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY R. NATHANSON | | | | | 22e. ADDRESS 51 FRANKLIN ST ANNAPOLIS, MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE April 1, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY St. Anne's | | 23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis AA MD | | |
| 24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel - Annapolis, MD | | | | | 25a. DATE REC'D. BY REGISTRAR APR 11 1984 | | 25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall | | |

MEDICAL CERTIFICATION

X
A

Handwritten notes on lined paper, including a large 'X' at the top left and a circled 'A' at the top right. The text is mostly illegible due to blurriness and bleed-through from the reverse side. Some legible fragments include:

- Top left: A large handwritten 'X'.
- Top right: A circled 'A'.
- Below 'X': Faint, illegible handwriting.
- Below 'A': Faint, illegible handwriting.
- Center: Faint, illegible handwriting.
- Bottom: Faint, illegible handwriting.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09221

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | | | | |
|--|--|-----------------------------|---|--|--|---|--|---|---|--|--|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) ETHIL E. VEIHMAYER | | | 2a. DATE OF DEATH
MONTH 4 DAY 7 YEAR 84 | | | 2b. HOUR
5:15 M | | | | | | | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
MONTH 10 DAY 10 YEAR 1889 | | 6. AGE (IN YEARS LAST BIRTHDAY)
95 YRS. | | 7. IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | 7. IF UNDER 24 HRS
HOURS 0 MIN. 0 | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
WASHINGTON, D.C. | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSPITAL | | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
HOMEMAKER | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
ANNAPOLIS | | | 13c. CITY OR TOWN
ANNAPOLIS | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS / ZIP CODE
614 WAYWARD DRIVE 21401 | | |
| 14. FATHER'S NAME
FIRST JOSEPH MIDDLE E. LAST MILLER | | | 15. MOTHER'S MAIDEN NAME
FIRST SALLIE MIDDLE TEAHUM | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | | 16b. SOCIAL SECURITY NO.
578-24-7926 | | | 17. INFORMANT
ADDRESS
DORIS E. BRUINSMA SAME AS 13E | | | | | | | | |

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|--|--|--|--|--|--|--|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Dehydration, Malnutrition
8842
DUE TO, OR AS A CONSEQUENCE OF
(b) Pain, Coma
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) Hip fracture
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3/29/84 | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
Old age - previous subdural hematoma | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR 3 A.M. MONTH 3 DAY 28 YEAR 1984
P.M. | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
Fell out of bed in N. Home | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY
(IF HOME, STREET AND CITY OR TOWN, COUNTY, STATE)
Paupers Rd N.H. | | | 21f. LOCATION
(STREET) CITY OR TOWN COUNTY STATE
Loop Road Crownsville, Md. | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/7/84 to 4/8/84 and that in (my) present opinion death occurred on the date and hour and from the causes stated above (If two) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Peter F. VerKouwen | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4/8/84 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
PETER F. VERKOUWEN | | | 22e. ADDRESS
1419 Forest Drive, Annapolis, Md, 21403 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | | | 23b. DATE
4-10-84 | | | 23c. NAME OF CEMETERY OR CREMATORY
LAKEMONT CEMETERY | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
DAVIDSONVILLE ANNE ARUNDEL CO MARYLAND | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT E. EVANS | | | ADDRESS
ANNAPOLIS, MARYLAND | | | 25a. DATE REC'D. BY REGISTRAR
APR 11 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson | | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



JACK

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09222

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|---|---|---|----------------------------|---|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
FIRST MIDDLE LAST
Quentell Violet | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 24 1984 | | 2b. HOUR
M
11 | | | | | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
MONTH DAY YEAR
April 5, 1998 | | 6. AGE (IN YEARS LAST BIRTHDAY)
86 | | 7. IF UNDER 1 YEAR
MONTHS DAYS
YRS. | | 8. IF UNDER 24 HRS.
HOURS MIN.
YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
New York | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County, MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Navy | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Defense | |
| 13a. STATE
MD | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
Malabar Landing 21403 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Atwood Violet | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Olga Quentell | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | | | 16b. SOCIAL SECURITY NO.
111-11-1111 | | 17. INFORMANT
Geraldine Violet | |
| 18. ADDRESS
Same as | | 19. ADDRESS
Same as | | 20. ADDRESS
Same as | | 21. ADDRESS
Same as | | 22. ADDRESS
Same as | | 23. ADDRESS
Same as | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

1579

IMMEDIATE CAUSE (a)

Carcinoma of pancreas with metastases.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

3 wks.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

Arteriosclerotic cardiovascular disease with congestive failure.

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. certify that (I) (this hospital) attended the deceased from
above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE
Richard N. Peeler MD | | 22c. DEGREE
MD | | 22d. DATE SIGNED
4/24/84 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22f. ADDRESS
51 Franklin St, Annapolis, MD | | | | | |

| | | | | | | | |
|---|--|------------------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
April 27, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington National | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Arlington VA | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
Taylor Funeral Chapel - Annapolis MD | | | | 25a. DATE REC'D. BY REGISTRAR
APR 26 1984 | | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Swanson-Randall | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

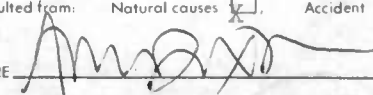
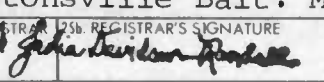
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(A)

Received of the
Honorable John A. ...
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for ...
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Received of the
Honorable John A. ...
the sum of ...
for ...
this ...

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXCLUDE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 9 2 2 3 | | | | | | | |
|--|--|-------------------------|--|---|--|--|--|--|--|---|--|---------------------------------------|--|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) FIRST MIDDLE LAST
MELISSA Louise Listman WARD | | | | | | | | | | 2a. DATE KNOWN OF DEATH
ESTIMATED April 2, 1984 | | 2b. HOUR
3:41 PM | | | | | |
| 1. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
March 6, 1983 | | 6. AGE (IN YEARS)
(LAST BIRTHDAY) YRS.
1 | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 2c. DATE PRONOUNCED DEAD
April 2, 1984 | | 2d. HOUR
3:41 PM | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Anne Arundel General Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
None | | 12b. KIND OF BUSINESS OR INDUSTRY
//////// | | | | | | | |
| 13a. STATE
Maryland | | | | | | | | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Annapolis | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
21401 1533 Hickory Wood Drive | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Frank W. Ward | | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Deborah E. Listman | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)
No | | | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
200/02/5030 | | 17. INFORMANT (Father) ADDRESS
Mr. Frank Ward Same as #13 | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
4871 IMMEDIATE CAUSE (a) Haemophilus influenzae sepsis with meningitis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:
(b) gitis
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY)
M.D. Assistant MEDICAL EXAMINER | | | | DATE SIGNED 4-3-84 | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT)
Ann M. Dixon, M.D. | | | | ADDRESS 111 Penn St., Balto., Md. 21201 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Cremation | | | | 23b. DATE
April 5, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Security Process, Inc. | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Catonsville Balt. Md. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home | | | | ADDRESS
Glen Burnie, Md | | 25. REGISTRAR'S SIGNATURE
 | | DATE
APR 8 1984 | | | | | | | | | |

UNITED STATES DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 09224 | | | | EDT | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT)
FIRST MIDDLE LAST
ROBERT O WARREN SR | | | | 2a. DATE OF DEATH MONTH DAY YEAR
APRIL 19, 1984 | | | | 2b. HOUR
0510 PM | | | |
| 3. SEX
MALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH MONTH DAY YEAR
MARCH 1, 1914 | | 6. AGE (IN YEARS LAST BIRTHDAY)
70 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
DELAWARE | | 7b. CITIZEN OF WHAT COUNTRY?
UNITED STATES | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
RETIRED SERVICE MGR | | 12b. KIND OF BUSINESS OR INDUSTRY (GOVT)
ANNE ARUNDEL Co. | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. STATE
MARYLAND | | | | 13b. COUNTY
ANNE ARUNDEL | | 13c. CITY OR TOWN
SEVERNA PARK | |
| 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 13e. STREET ADDRESS
407 SOUTH DR. | | | | 21146 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
OSCAR BENNETT WARREN | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
LENA MAY SMITH | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
NO | | | | 16b. SOCIAL SECURITY NO.
218-07-8210 | | 17. INFORMANT ADDRESS
VIOLET L. WARREN (SAME AS 13) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c) years | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Sudden | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a. | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-12-84 to 4-19-84, that (I) (we) lost saw the deceased alive on 4-12-84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
JACK I. STERN M.D. | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
4-19-84 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
JACK I. STERN M.D. | | | | 22e. ADDRESS
300 HOSPITAL DRIVE # 135
GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | | | 23b. DATE
APRIL 23, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE
GLEN BURNIE ANNE ARUNDEL MD. | | | |
| 24. FUNERAL DIRECTOR NAME
BARRANCO FUNERAL HOME | | | | 501 RITCHIE HWY.
SEVERNA PARK, MD | | 25a. DATE REC'D. BY REGISTRAR
APR 25 1984 | | | | | |
| 25b. REGISTRAR'S SIGNATURE
Julia Davidson | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use at the burial-transit permit. Then please reinsert certificate pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

85-980-1234

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH09225
REG. NO.

| | | | | | | | | | | | | | |
|---|--|--|--|---|-----------------------------------|--|---|--|---|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Lillian Beasley Waters | | | 2a. DATE OF DEATH
April 2, 1984 | | | 2b. HOUR
M | | | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Jan. 22, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
90 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
Severna Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT BY SUCH FACILITY, GIVE STREET ADDRESS)
Meridian Severna Park Nursing Home | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
A.A. | | 13c. CITY OR TOWN
Severna Park | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
12 Linstead Road 21146 | | | | |
| 14. FATHER'S NAME
George Thomas Beasley | | | | | | 15. MOTHER'S MAIDEN NAME
Mary Ellen Downs | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
No | | | 16b. SOCIAL SECURITY NO.
216-46-6872 | | | 17. INFORMANT (Daughter) ADDRESS
Mrs. Mary McGoury Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Being Bedridden</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Degenerative Osteoarthritis</u>
7159 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>ASCVD</u> | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 3-31</u> 19 <u>84</u> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (I have) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>A.G. Alexander</u> | | | | | | DEGREE
<u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4-2-84 | | | |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)
A.G. Alexander | | | | | | 23b. ADDRESS
1300 Ritchie Hwy. Arnold 21012 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | 23b. DATE
April 4, 1984 | | | 23c. NAME OF CEMETERY OR CREMATORY
Epiphany Cemetery Odenton | | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
A.A. Maryland | | | | |
| 24. FUNERAL DIRECTOR
Singleton Funeral Home Glen Burnie, Md | | | | | | 25a. DATE REC'D. BY REGISTRAR
APR 3 1984 | | | | | | 25b. REGISTRAR'S SIGNATURE
<u>Jane Davidson-Randall</u> | |

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11/15/11

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11/15/11

11/15/11

20%

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of such event.

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 09226 | |
|---|--|--|---|------------------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | EST | |
| 1. DECEASED NAME
(TYPE OR PRINT) | | 2. DATE OF DEATH | | 3. HOUR | |
| John Wayson, Sr. | | APRIL 13, 1984 | | 8:55 A | |
| 3 SEX | 4 RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS LAST BIRTHDAY) | 7. IF UNDER 1 YEAR | |
| Male | White | Aug. 19, 1898 | 85 | MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9. CITIZEN OF WHAT COUNTRY? | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | 11. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Maryland | U.S.A. | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | ANNE ARUNDEL COUNTY MD. | | |
| 12. CITY OR TOWN OF DEATH | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | |
| GLEN BURNIE | NORTH ARUNDEL HOSPITAL | Sales Motor Tank Man Exxon | | | |
| 15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | 16. INSIDE CITY LIMITS? | 17. STREET ADDRESS | | | |
| Maryland | YES <input type="checkbox"/> NO <input type="checkbox"/> | 21090 600 South Camp Meade Rd. | | | |
| 18. FATHER'S NAME | 19. MOTHER'S MAIDEN NAME | 20. KIND OF BUSINESS OR INDUSTRY | | | |
| Benjamin Wayson | Alice Wilkinson | | | | |
| 21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | 22. SOCIAL SECURITY NO. | 23. INFORMANT (Wife) ADDRESS | | | |
| No | 217/01/4953 | Mrs. Emma V. Wayson Same as #13 | | | |
| 24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) 4292 | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) AC-CVD | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c) Aspiration pneumonia | | | | | |
| 25. DATE OF OPERATION | 26. CONDITION FOR WHICH OPERATION WAS PERFORMED | 27. AUTOPSY? | 28. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | YES <input type="checkbox"/> NO <input type="checkbox"/> | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 29. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 30. TIME OF INJURY | 31. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| | HOUR A.M. MONTH DAY YEAR | | | | |
| 32. INJURY OCCURRED | 33. PLACE OF INJURY | 34. LOCATION | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | STREET CITY OR TOWN COUNTY STATE | | | |
| 35. I certify that (I) (this hospital) attended the deceased from 4/13/84 to 4/13/84, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 36. SIGNATURE | 37. DEGREE | 38. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 39. DATE SIGNED | |
| Elmo M. Gayoso, M.D. | M.D. | | | 4/13/84 | |
| 40. PHYSICIAN'S NAME (TYPE OR PRINT) | 41. ADDRESS | 42. NAME OF CEMETERY OR CREMATORY | | | |
| ELMO M. GAYOSO, M.D. | 273-F PENINSULA FARM ROAD ARNOLD, MARYLAND 21012 | Glen Haven Mem. Prk. Glen Burnie A.A. Md. | | | |
| 43. BURIAL, CREMATION, REMOVAL (SPECIFY) | 44. DATE | 45. LOCATION | | | |
| Burial | April 16, 1984 | CITY OR TOWN COUNTY STATE | | | |
| 46. FUNERAL DIRECTOR | 47. DATE REC'D. BY REGISTRAR | 48. REGISTRAR'S SIGNATURE | | | |
| Singleton Funeral Home | APR 17 1984 | John Davidson | | | |

BP



RECEIVED

NOV 19 1964

NOV 19 1964

NOV 19 1964

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cardposters. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09227

REG. NO.

| | | | | | | | | | | | |
|---|--|--|--|---|--------------|--|-------------------|--|----------|----------------------------------|---|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST
Francis | MIDDLE
E. | LAST
WEEDEN | 2a. DATE OF DEATH | MONTH
APRIL | DAY
4 | YEAR
1984 | 2b. HOUR
1625 M |
| 3. SEX
MALE | | 4. RACE
NEGRO | | 5. DATE OF BIRTH
MONTH
June 13, 1918 | | 6. AGE (IN YEARS LAST BIRTHDAY)
65 | | IF UNDER 1 YEAR
MONTHS
DAYS | | IF UNDER 24 HRS
HOURS
MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Rhode Island | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel County MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
Ft. Meade, Md. | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
Kimbrough Army Community Hospital | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Retired Army | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
A. Arundel | | 13c. CITY OR TOWN
Laurel | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS
336 Coke Land, S. Laurel | | 20707 | |
| 14. FATHER'S NAME
FIRST
Norman D. Weeden | | | | 15. MOTHER'S MAIDEN NAME
FIRST
Julia White Seamon | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
1943-1966 | | 17. INFORMANT
Ruth H. Weeden (Wife) | | ADDRESS
same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>PNEUMONIA</u>
<u>1629</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>METASTATIC LUNG CANCER</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>2 DAYS</u>
<u>6 YRS</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET | | CITY OR TOWN | | COUNTY | | STATE | |
| 22. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>4 APRIL</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>4 APRIL</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Saunders</u> | | DEGREE
MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<u>4 April 84</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Henry Saunders, CPT, MC | | | | 22e. ADDRESS
Kimbrough Army Community Hospital, Ft. Meade | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4-10-84 | | 23c. NAME OF CEMETERY OR CREMATORY
Arlington Nat'l Cem. | | 23d. LOCATION
CITY OR TOWN
Arlington, Virginia | | COUNTY | | STATE | |
| 24. FUNERAL DIRECTOR
NAME
George R. Snowden | | 24b. ADDRESS
246 N. Washington St.
Rockville, Md. 20850 | | 25a. DATE REC'D. BY REGISTRAR
APR 9 1984 | | 25b. REGISTRAR'S SIGNATURE
<u>John T. ...</u> | | | | | |



30% COTTON

EXHIBIT



U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.
OFFICE OF THE ASSISTANT SECRETARY
PLANT INDUSTRY
WASHINGTON, D.C.
EXHIBIT
11
30% COTTON
U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C.
OFFICE OF THE ASSISTANT SECRETARY
PLANT INDUSTRY
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | | 09228 | |
|--|--|--|--|--|---|---|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | EST | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) JESSE Lee WELLS | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
APRIL 20, 1984 | | 2b. HOUR
400 PM | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
May 24, 1916 | | 6. AGE (IN YEARS LAST BIRTHDAY)
67 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Kentucky | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Ret. Iron Worker | | 12b. KIND OF BUSINESS OR INDUSTRY
Union Local 16 | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS
313 Oak Manor Drive 21061 | | | | |
| 13a. STATE
Maryland | | 13b. COUNTY
Anne Arundel | | 13c. CITY OR TOWN
Glen Burnie | | | | | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Roe Wells | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Lizzie Otten | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
400-18-8452 | | 17. INFORMANT
ADDRESS
Velna M. Wells Same as #13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4100 IMMEDIATE CAUSE (a) Coronary Artery
DUE TO, OR AS A CONSEQUENCE OF
(b) Myocardial Infarction with
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(c) Cardiogenic Shock | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4. 14. 84 to 4. 20. 84 , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on 4. 20. 84 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Lily Mae M.D. | | | | DEGREE
M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
4. 23. 84 | | | |
| 22d. PHYSICIAN'S NAME
CHACKIMKAL V. CYRIAC, M.D. | | | | 22e. ADDRESS
GLEN BURNIE, MARYLAND 21061 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | | | 23b. DATE
4/24/1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Hill Cemetery | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Baltimore, A. A. Co., Md. | | | |
| 24. FUNERAL DIRECTOR
NAME
McCully Funeral Homes | | | | BALTIMORE, MD., 21225
237 E. Patapsco Ave. | | | | 25a. DATE REC'D. BY REGISTRAR
APR 26 1984 | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson | |

BP _____



[The page contains extremely faint, illegible text, likely bleed-through from the reverse side. The text is organized into several horizontal sections, possibly representing a list or a table. Some words are difficult to discern but appear to include:]

[Faint text at the top:] ...
[Faint text in the middle:] ...
[Faint text at the bottom:] ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 and 2 should be filed within 72 hours after death. Page 3 should be filed within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09229

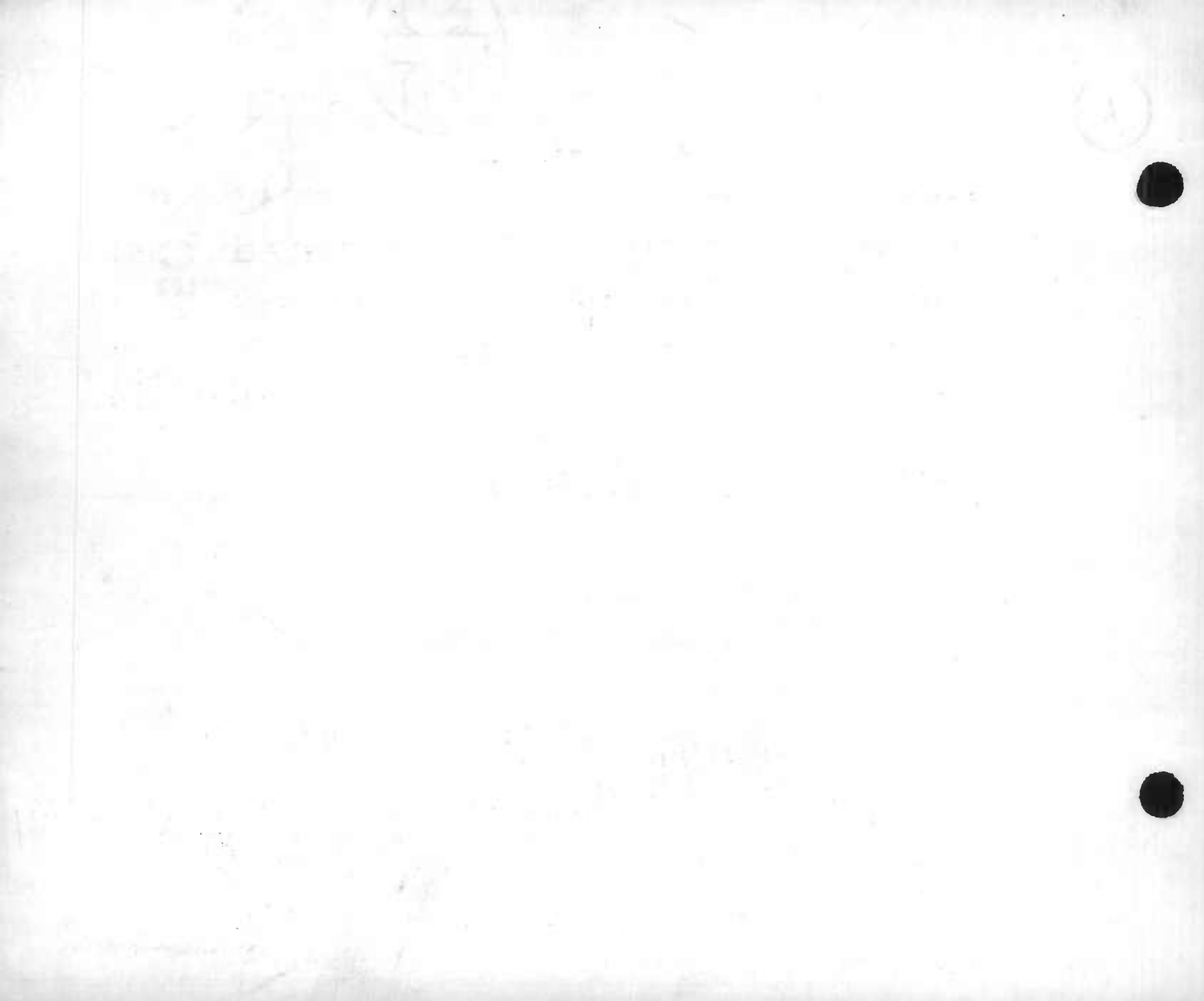
EDT

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | | | |
|--|--|--|--|---|---|---|---|---|--|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) SHIRLEY M WELSH | | | 2a. DATE OF DEATH
MONTH APRIL DAY 29 YEAR 1984 | | | 2b. HOUR
702 AM | | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH Sept. DAY 22 YEAR 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY)
89 YRS. | | 7. IF UNDER 1 YEAR
MONTHS DAYS | | 8. IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Georgia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | | | | |
| 10. CITY OR TOWN OF DEATH
GLEN BURNIE | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
NORTH ARUNDEL HOSPITAL | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Floral - Ret. | | | 12b. KIND OF BUSINESS OR INDUSTRY
Florist | | |
| 13a. STATE
Maryland | | | 13b. COUNTY
AA | | 13c. CITY OR TOWN
Glen Burnie | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
18 Sumac Road 21061 | | |
| 14. FATHER'S NAME
FIRST James MIDDLE T. LAST Pritchett | | | | 15. MOTHER'S MAIDEN NAME
FIRST Amanda MIDDLE LAST N/A | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO.
220-24-6501 | | | 17. INFORMANT
ADDRESS
Glen Burnie, MD
William Hagedorn, 7432 Classic Drive | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4140
DUE TO, OR AS A CONSEQUENCE OF (b) @ HF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. F I S A D
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY
(HOMES, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/28/84 19, to 4/29/84 19, that (I) (we) lost view of the deceased above on 4/28/84 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Dr. B. Ramirez | | | DEGREE
MD | | | 22c. DATE SIGNED
4/29/84 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DR. B. RAMIREZ | | | 22e. ADDRESS
7845 OAKWOOD ROAD, SUITE 205
GLEN BURNIE, MARYLAND 21061 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY) Burial | | | 23b. DATE
1 May 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Park | | | 23d. LOCATION
CITY OR TOWN Glen Burnie COUNTY AA STATE MD | | | |
| 24. FUNERAL DIRECTOR
NAME James S. Kirkley, Glen Burnie, MD ADDRESS | | | | | | 25a. DATE REC'D. BY REGISTRAR MAY 1 1984 25b. REGISTRAR'S SIGNATURE John Davidson | | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | 09230 | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR (ELTON T. WENRICH) | | | | REG. NO. | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) ELTON T WENRICH | | | | 2a. DATE OF DEATH MONTH DAY YEAR
4-18-84 | | | |
| 3. SEX
Male | | | | 2b. HOUR
2A M | | | |
| 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
7 21 12 | | 6. AGE (IN YEARS LAST BIRTHDAY)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | | | |
| 10. CITY OR TOWN OF DEATH
Severna Park | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
24 Holly Rd. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
ENGINEER (RET) | | 12b. KIND OF BUSINESS OR INDUSTRY
WESTINGHOUSE | |
| 13a. STATE
MARYLAND | | | | 13b. COUNTY
ANNE ARUNDEL | | | |
| 13c. CITY OR TOWN
SEVERNA PARK | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 13e. STREET ADDRESS
24 HOLLY RD | | | | 13f. STREET ADDRESS
21146 | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
ORVILLE WENRICH | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
JENNIE KENDALL | | 17. INFORMANT ADDRESS
MICHAEL E. WENRICH 1031 LAKE CLARIE DR. ANNAPOLIS, MD. 21401 | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
NO | | 16b. SOCIAL SECURITY NO.
— | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
4019 IMMEDIATE CAUSE (a) Generalized Arteriosclerotic Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertension
DUE TO, OR AS A CONSEQUENCE OF
(c) — | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9/1 , 19 72 , to 4/18 , 19 84 , that (I) (we) last saw the deceased alive on 3/13 , 19 84 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Donald Hislop | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
4-18-84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Donald Hislop | | 22e. ADDRESS
ROBINSON RD SEVERNA PARK, MD 21146 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
BURIAL | | 23b. DATE
APRIL 21, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
GLEN HAVEN CEMETERY | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
GLEN BURNIE ANNE ARUNDEL MD. | |
| 24. FUNERAL DIRECTOR
NAME
ROBERT S. BARRANCO | | ADDRESS
501 RITCHIE HWY SEVERNA PARK, MD. | | DATE REC'D. BY REGISTRAR
APR 23 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson Kendall | |

BP

1. Mr. J. H. [illegible]
 2. Mr. [illegible]
 3. Mr. [illegible]
 4. Mr. [illegible]
 5. Mr. [illegible]
 6. Mr. [illegible]
 7. Mr. [illegible]
 8. Mr. [illegible]
 9. Mr. [illegible]
 10. Mr. [illegible]
 11. Mr. [illegible]
 12. Mr. [illegible]
 13. Mr. [illegible]
 14. Mr. [illegible]
 15. Mr. [illegible]
 16. Mr. [illegible]
 17. Mr. [illegible]
 18. Mr. [illegible]
 19. Mr. [illegible]
 20. Mr. [illegible]
 21. Mr. [illegible]
 22. Mr. [illegible]
 23. Mr. [illegible]
 24. Mr. [illegible]
 25. Mr. [illegible]
 26. Mr. [illegible]
 27. Mr. [illegible]
 28. Mr. [illegible]
 29. Mr. [illegible]
 30. Mr. [illegible]
 31. Mr. [illegible]
 32. Mr. [illegible]
 33. Mr. [illegible]
 34. Mr. [illegible]
 35. Mr. [illegible]
 36. Mr. [illegible]
 37. Mr. [illegible]
 38. Mr. [illegible]
 39. Mr. [illegible]
 40. Mr. [illegible]
 41. Mr. [illegible]
 42. Mr. [illegible]
 43. Mr. [illegible]
 44. Mr. [illegible]
 45. Mr. [illegible]
 46. Mr. [illegible]
 47. Mr. [illegible]
 48. Mr. [illegible]
 49. Mr. [illegible]
 50. Mr. [illegible]
 51. Mr. [illegible]
 52. Mr. [illegible]
 53. Mr. [illegible]
 54. Mr. [illegible]
 55. Mr. [illegible]
 56. Mr. [illegible]
 57. Mr. [illegible]
 58. Mr. [illegible]
 59. Mr. [illegible]
 60. Mr. [illegible]
 61. Mr. [illegible]
 62. Mr. [illegible]
 63. Mr. [illegible]
 64. Mr. [illegible]
 65. Mr. [illegible]
 66. Mr. [illegible]
 67. Mr. [illegible]
 68. Mr. [illegible]
 69. Mr. [illegible]
 70. Mr. [illegible]
 71. Mr. [illegible]
 72. Mr. [illegible]
 73. Mr. [illegible]
 74. Mr. [illegible]
 75. Mr. [illegible]
 76. Mr. [illegible]
 77. Mr. [illegible]
 78. Mr. [illegible]
 79. Mr. [illegible]
 80. Mr. [illegible]
 81. Mr. [illegible]
 82. Mr. [illegible]
 83. Mr. [illegible]
 84. Mr. [illegible]
 85. Mr. [illegible]
 86. Mr. [illegible]
 87. Mr. [illegible]
 88. Mr. [illegible]
 89. Mr. [illegible]
 90. Mr. [illegible]
 91. Mr. [illegible]
 92. Mr. [illegible]
 93. Mr. [illegible]
 94. Mr. [illegible]
 95. Mr. [illegible]
 96. Mr. [illegible]
 97. Mr. [illegible]
 98. Mr. [illegible]
 99. Mr. [illegible]
 100. Mr. [illegible]



APR 23 1984
 [illegible text]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09231

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Arvine F. Wetzel</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR
<i>4/24/84</i> | | 2b. HOUR
<i>3 AM</i> M. |
| 3. SEX
<i>Male</i> | 4. RACE
<i>white</i> | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>6 11 08</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>75</i> YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Ohio</i> | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Anne Arundel Co.</i> MD. | |
| 10. CITY OR TOWN OF DEATH
<i>Glen Burnie Md.</i> | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>WANC 313 Hosp. A. B. Md.</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>meat cutter</i> | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Superior</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
<i>Md.</i> | 13b. COUNTY
<i>A.A. Co.</i> | 13c. CITY OR TOWN
<i>Odenton</i> | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
<i>538 maple Ridge Lane 21113</i> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>Howard Wetzel</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Emma Kuntz</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>no</i> | | 16b. SOCIAL SECURITY NO.
<i>280-09-7831</i> | | 17. INFORMANT
ADDRESS
<i>Keith T. Wetzel 538 Maple Ridge Odenton, Md. 21113</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for part 1, 1b, and 1c)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4960 Cardio-pulmonary arrest</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Chronic obstructive lung disease</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 hour</i>
<i>2 years</i> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1
<i>none</i> | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>2/5 8 4/24 84</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4/22 1984</i> to <i>4/24 84</i> , that (I) (we) lost saw the deceased alive on <i>4/22 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
<i>R. M. McLaughlin, M.D.</i> | | DEGREE | | 22c. DATE SIGNED
<i>4/24/84</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>McLaughlin</i> | | 22e. ADDRESS
<i>3708 Mountain Rd. Pasadena, Md</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | 23b. DATE
<i>4/27/84</i> | 23c. NAME OF CEMETERY OR CREMATORY
<i>St Barbara Church</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Massillon Ohio 21122</i> | |
| 24. FUNERAL DIRECTOR
NAME
<i>Hardesty Funeral Home</i> | | ADDRESS
<i>12 Ridgely Ave Ann. Md. 21144</i> | | 25. DATE REC'D. BY REGISTRAR
<i>APR 25 1984</i> | |
| | | 26. REGISTRAR'S SIGNATURE
<i>John Davidson</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C. 20250

LIBRARY
U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C. 20250



LIBRARY
U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY
WASHINGTON, D.C. 20250



BP _____
DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of 4.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death where the State Dept. of Health and Mental Hygiene is located. If item 21 is marked on item 18, the medical examiner must be notified of the death. If item 21 is marked on item 18, the medical examiner must be notified of the death.

Reviewed *William J. Jones* M.D. *4/12/84* *AA*

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | REG. NO. 09232 | | | |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 26. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME (TYPE IN PRINT) FIRST MIDDLE LAST
Vernon Richard Wheeler | | | | 26. DATE OF DEATH MONTH DAY YEAR
4/1/84 | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH MONTH DAY YEAR
5-19-1902 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS
81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Sahdy Side, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co. MD. | |
| 10. CITY OR TOWN OF DEATH
Shady Side | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
4944 Beach St. | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)
tool maker | | 12b. KIND OF BUSINESS OR INDUSTRY
aviation | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN
Md. B.A. Co. Shady Side | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS
4944 Beach St. | | 13d. STREET ADDRESS
20764 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST
Joseph Wheeler | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST
Iva Bast | | 16. ADDRESS
4944 Beach Dr. Shady Side, Md. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)
no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)
no | | 17. INFORMANT
Mrs. Vernon Wheeler | | | |
| 18. CAUSE OF DEATH (Enter only one cause for Part 1. Death was caused by IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 4100 Acute Coronary occlusion | | | | one hour | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | Coronary Arteriosclerosis | | | |
| | | | | years | | | |
| | | | | years | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| Fractured right hip July 83; Stroke October 83; Bed Sores | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
— | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
— | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE
— | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/12/82 , 19____, to 4/1/84 , 19____, that (I) (we) last saw the deceased on 4/1/84 , 19____, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) sew the body after death. | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN
Charles H. Wirth | | | | DEGREE
MD | | 22c. DATE SIGNED
4/2/84 | |
| 22d. PHYSICIAN'S NAME (TYPE IN PRINT)
Charles H. Wirth | | | | 22e. ADDRESS
Lothian Md 20711 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
Burial | | 23b. DATE
4/4/84 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodfield Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE
Galesville A.A. Co. Md. | |
| 24. FUNERAL DIRECTOR NAME
Hardesty Funeral Home | | | | 25a. DATE REC'D. BY REGISTRAR
APR 6 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |
| ADDRESS
12 Ridgely Av Ann. Md. | | | | | | | |

1

Thomas
White

White
2-11-1881

White
4/18/81

24

in
year
year

White
White
White

White
White
White

White
4/18/81

White
4/18/81

White
4/18/81

White
4/18/81

White
4/18/81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) Benjamin Daniel White | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 30 1984 | | 2b. HOUR
A.M. |
| 3. SEX
Male | 4. RACE
Caucasian | 5. DATE OF BIRTH
MONTH DAY YEAR
Dec. 23, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY)
63 YRS. | # UNDER 1 YEAR
MONTHS DAYS
63 |
| 7a. BIRTHPLACE
(STATE OR FOREIGN COUNTRY)
South Carolina | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel Co., MD. | |
| 10. CITY OR TOWN OF DEATH
Annapolis | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
2508 Lyons Drive | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Physician | | 12b. KIND OF BUSINESS OR INDUSTRY
Public Health |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
MD | 13b. COUNTY
AA | 13c. CITY OR TOWN
Annapolis | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS / ZIP CODE
2508 Lyons Drive 21403 | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Cecil G. White | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Mabel Holloway | | 16. ADDRESS
Same as #13 | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
Yes | | 16b. SOCIAL SECURITY NO.
WW11 212-34-4125 | | 17. INFORMANT
John Pitt | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Sudden death
4019
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
DUE TO, OR AS A CONSEQUENCE OF | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hypertension, gouty arthritis. | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
2 83 76
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/> | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
205 Ridgely Ave Annapolis 21401 | |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
George C. Samaras | | 22c. DATE SIGNED
4/30/84 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 23a. BURIAL, CREMATION, REMOVAL
(CHECK)
Burial | | 23b. DATE
May 3, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenville Memorial Gardens | |
| 24. FUNERAL DIRECTOR
NAME
Taylor Funeral Chapel - Annapolis MD | | 25a. DATE REC'D. BY REGISTRAR
MAY 2 1984 | | 25b. REGISTRAR'S SIGNATURE
John Davidson-Randall | |

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 2 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|---|--|---|--|---|--|---|--|
| 1- FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME
(TYPE OR PRINT) <i>Wilma M. Wilcox</i> | | | | | 2a. DATE OF DEATH
MONTH DAY YEAR
<i>4 28 84</i> | | | 2b. HOUR
M
<i>---</i> | |
| 3 SEX
<i>female</i> | | 4 RACE
<i>white</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>March 24, 1918</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
YRS. <i>66</i> | | IF UNDER 1 YEAR
MONTHS DAYS
<i>---</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
<i>Vienna Ohio</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Anne Arundel Co. MD</i> | | | |
| 10. CITY OR TOWN OF DEATH
<i>Edgewater</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>444 Riverview Dr.</i> | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>never emp.</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>---</i> | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 13a. STATE
<i>Md.</i> | | 13b. COUNTY
<i>A.A. Co.</i> | | 13c. CITY OR TOWN
<i>Edgewater</i> | | 13e. STREET ADDRESS
<i>444 Riverview Dr</i> | | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>William E. Wilcox</i> | | | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Essaline Kirkwood</i> | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO.
<i>302-20-8013</i> | | 17. INFORMANT
ADDRESS
<i>Anne Johe 444 Riverview Av. Edgewater, Md. 21037</i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 months</i> | | | |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c)
PART 1. DEATH WAS CAUSED BY:
<i>1991</i> IMMEDIATE CAUSE (a) <i>Metastatic Sarcomous Cell Cancer</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>---</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (c) <i>---</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>---</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>~ 19 81</i> to <i>present</i> 19 <i>---</i> , that (I) was lost saw the deceased alive on <i>4/27 19 84</i> , and that in (my) best opinion death occurred on the date and hour and from the causes stated above. (I) was (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>[Signature]</i> | | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>JACK TEITELBAUM MD</i> | | | | | 22e. ADDRESS
<i>139 Old Solomon Lsc., Annapolis MD</i> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>5/3/84</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Vienna Township Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Vienna Trumble Co Ohio</i> | | | |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
<i>Hardesty Funeral Home Ann. Md. 21401</i> | | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAY 1 - 1984</i> | | 25b. REGISTRAR'S SIGNATURE
<i>[Signature]</i> | | |

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ST-14



ST-14



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

0 9 2 3 5

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | |
|--|---|---|---|---------------------------------------|---|
| 1. DECEASED NAME
(TYPE OR PRINT) Thomas P WILKERSON | | | 2a. DATE OF DEATH
MONTH DAY YEAR
4-24-84 | | 2b. HOUR
6:39^P |
| 3. SEX
M | 4. RACE
2 2 | 5. DATE OF BIRTH
MONTH DAY YEAR
7 25 26 | 6. AGE (IN YEARS LAST BIRTHDAY)
57 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH
ANNE ARUNDEL COUNTY MD. | | |
| 10. CITY OR TOWN OF DEATH
ANNAPOLIS | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GENERAL HOSPITAL | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE) | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE
MARYLAND | | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
ANNAPOLIS | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
MARION WILKERSON | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
CHRISTINE WILKERSON | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
YES | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
W.W. II | 17. INFORMANT
ADDRESS
DAVID WILKERSON 1843 Bowman Ct. Annapolis, Md. 21401 | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:**4140**

IMMEDIATE CAUSE (a)

CARDIOPULMONARY ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b) **Atherosclerotic Coronary Artery Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH**4 days**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

MEDICAL CERTIFICATION

| | | | |
|--|---|--|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/20/84 , 19____, to 4/24/84 , 19____, that (I) (we) last
saw the deceased alive on 4/24/84 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated
above, (I) (we) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE
Robert M. Greenfield | DEGREE
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Robert M. Greenfield, M.D. | 22e. ADDRESS | | |

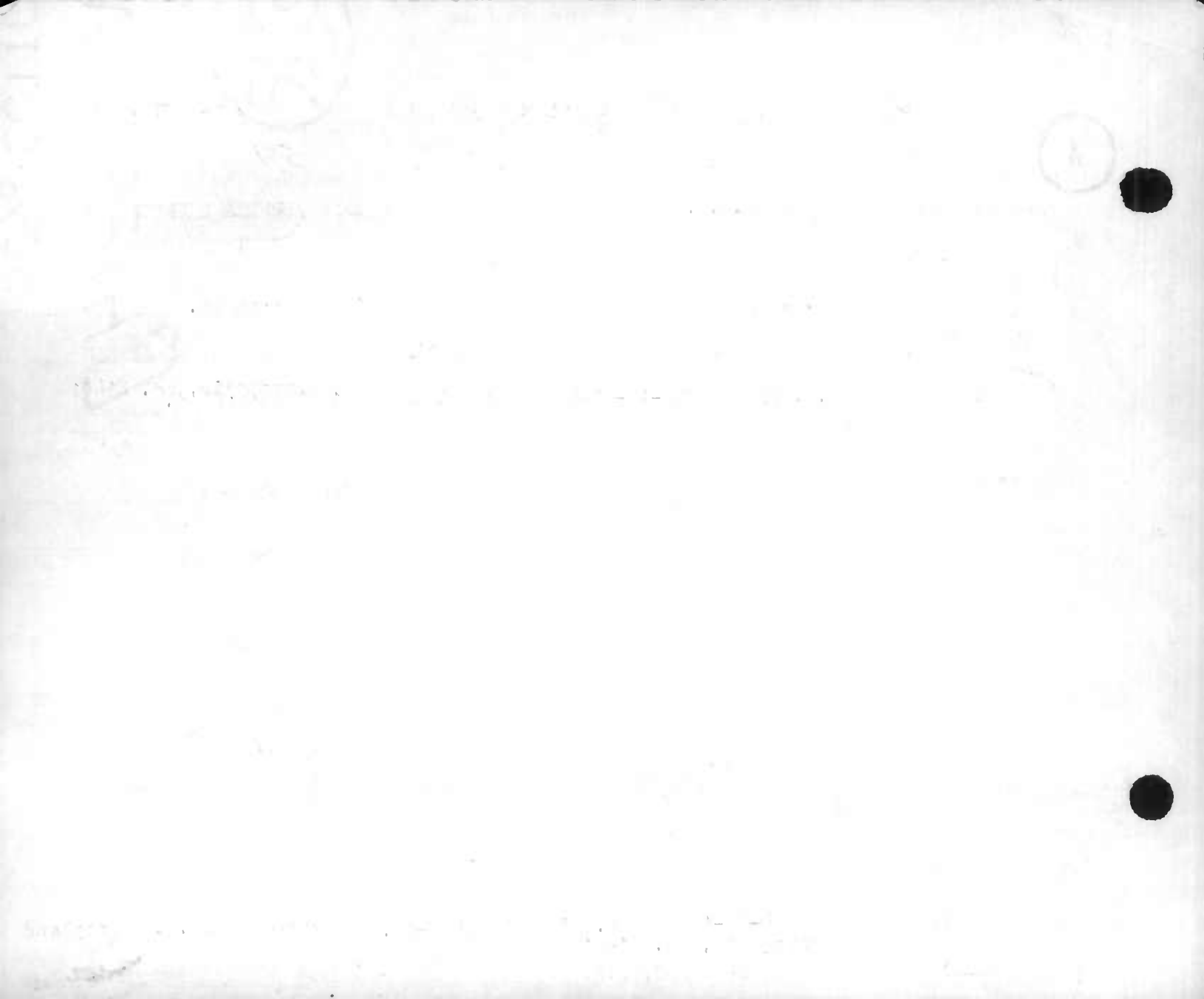
| | | | |
|--|-------------------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
BURIAL | 23b. DATE
4-28-1984 | 23c. NAME OF CEMETERY OR CREMATORY
Mt. Zion Church Ceme. | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Lothian A.A. Maryland |
| 24. FUNERAL DIRECTOR
NAME ADDRESS
WILLIAM REESE & SONS MORTUARY, P.A. | | 25a. DATE REC'D. BY REGISTRAR
APR 26 1984 | |
| | | 25b. REGISTRAR'S SIGNATURE
Julia Davidson-Rodriguez | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with you in 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

09236

FOR
1 - STATE
REGISTRAR

REG. NO.

| | | | | | |
|---|---|---|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
George Washington Wilson, Jr. | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 10, 1984 | | 2b. HOUR
12:20 P. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
MONTH DAY YEAR
June 11, 1904 | | 6. AGE (IN YEARS LAST BIRTHDAY)
79 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS
HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN)
IND. | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | |
| 10. CITY OR TOWN OF DEATH
Glen Burnie | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
209 Sandsbury Ave. | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Book Keeper | 12b. KIND OF BUSINESS OR INDUSTRY
Exxon | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | 13b. COUNTY
A.A. | 13c. CITY OR TOWN
Glen Burnie | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
George W. Wilson IV | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Nelle Flegal | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE YEAR OR DATES)
212/09/0192 | | 17. INFORMANT (Son)
ADDRESS
George Wilson V Severn, Maryland | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
1629 IMMEDIATE CAUSE (a) C.A. ghrng
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a
COPD | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY BY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED
(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/12/84 1984 to 4/10/84 1984, that (I) (we) last saw the deceased alive on 3/27/84 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Dr. David Schwartz | | | | 22c. DATE SIGNED
4/10/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
Dr. David Schwartz | | | | 22e. ADDRESS
7845 Oakwood Road - Glen Burnie | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
April 13, 1984 | | 23c. NAME OF CEMETERY OR CREMATORY
Glen Haven Mem. Prk. Glen Burnie A.A. Md. | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home | | 24b. ADDRESS
Glen Burnie, Md | | 25a. DATE REC'D BY REGISTRAR
APR 12 1984 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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P2 01/10 10:15

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20% C III

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of occurrence.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

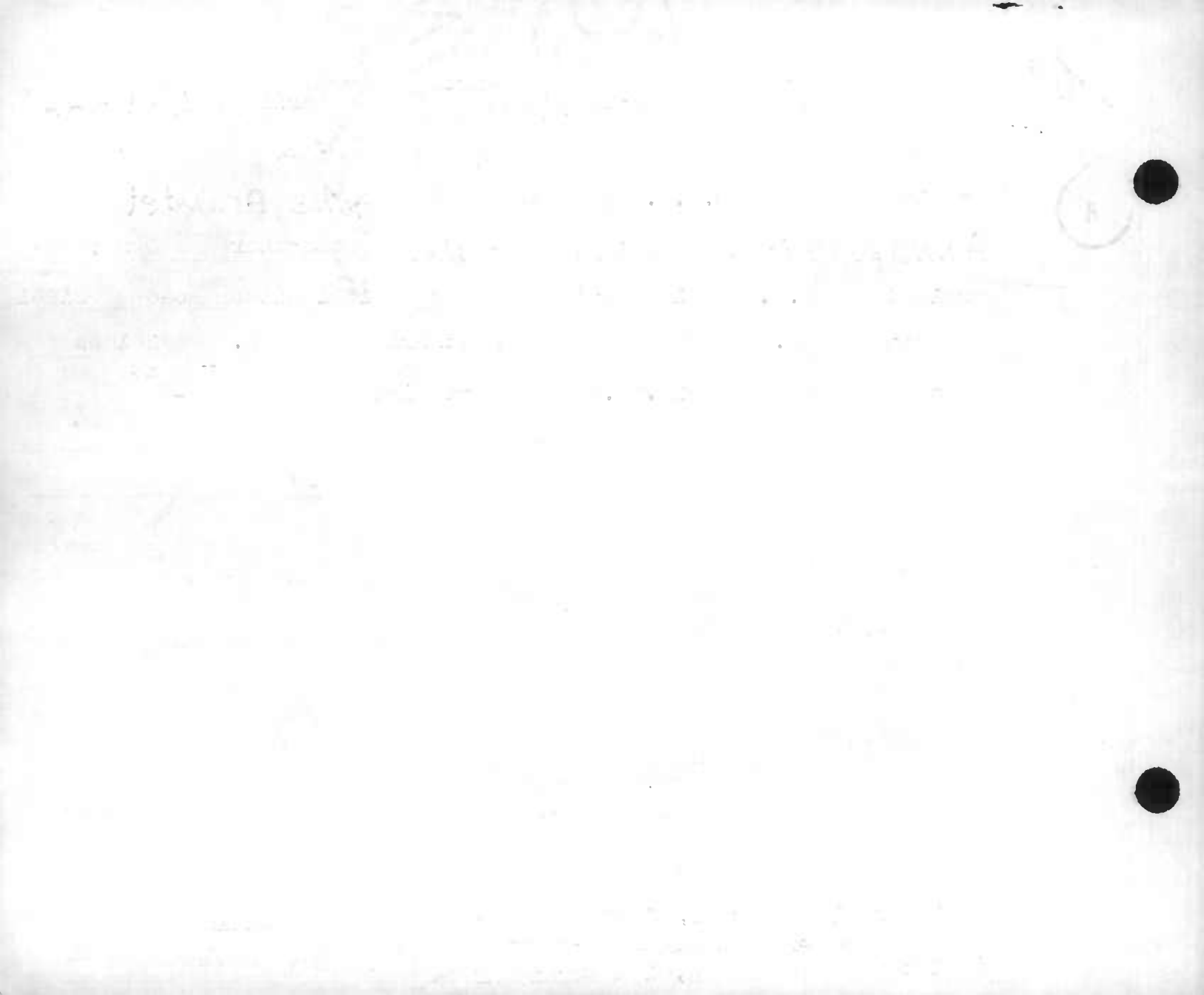
09237

FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|--|---|---|--|---|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT)
Grace Elizabeth Wirth | | | 2a. DATE OF DEATH
MONTH DAY YEAR
April 8/84 | | | 7b. HOUR
6:40A M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
MONTH DAY YEAR
July 29 01 | | 6. AGE (IN YEARS LAST BIRTHDAY)
82 YRS. | | 7a. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
Anne Arundel MD. | | | |
| 10. CITY OR TOWN OF DEATH
Annapolis | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
ANNE ARUNDEL GEN. | | | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
Homemaker | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (NURSING HOME OR OTHER INSTITUTION; GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE
Maryland | | | 13b. CITY OR TOWN
A.A. | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS / ZIP CODE
1221m Wilson Road 21061 | | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
Noah O. Tracey | | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
Catherine A. Holmes | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
No | | 16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)
None | | 17. INFORMANT
Son
Robert Wirth | | ADDRESS
Same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASCVD
2500
DUE TO, OR AS A CONSEQUENCE OF
(b) Diabetes mellitus
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)
Transitional Cell Ca URETER; WOUND INFECTION | | | | | | | | | |
| 19a. DATE OF OPERATION
3/20/84 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Cancer Ureter | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED
IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 3/20/84, 19, to 4/8/84, 19, that (1) (we) lost saw the deceased alive on 3/2/84, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
David S McHold MD | | | | DEGREE
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED
4/8/84 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
DAVID S McHold | | | | 22e. ADDRESS
16 MURRAY AVE | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
Burial | | 23b. DATE
Apr 11, 84 | | 23c. NAME OF CEMETERY OR CREMATORY
Md Veterans Cem | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
Crownsville AA MD | | | |
| 24. FUNERAL DIRECTOR
NAME
Singleton Funeral Home, Glen Burnie MD | | | | 25a. DATE REC'D. BY REGISTRAR
APR 10 1984
25b. REGISTRAR'S SIGNATURE
Julia Davidson-Randall | | | | | |

BP



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9 2 3 8

REG. NO.

| | | | | | | | | |
|--|--|-------------------|--|---|---|--------------------------------------|---|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR | | |
| HENRY Porter WITHERSPOON | | | 4-3-84 | | | 19 | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | IF UNDER 1 YR. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD | 7d. BALTIMORE CITY OR COUNTY OF DEATH | |
| Male | Cauc. | Dec. 6, 1954 | 29 YRS. | | | 4-3-84 | Anne Arundel County | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Washington DC | USA | | | | | Anne Arundel County | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Annapolis | Anne Arundel General Hospital | | | Student | | | School | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | |
| 13a. STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET ADDRESS | | | | |
| MD | AA | Edgewater | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 1117 Paca Drive 21037 | | | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16. SOCIAL SECURITY NO. | | |
| Fred L. Witherspoon Jr. | | | Bettie Porter | | | 219-64-7320 | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | 17. INFORMANT | | | 18. ADDRESS | | |
| NO | | | Fred L. Witherspoon, Jr. | | | Same as #13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | |
| PART 1 DEATH WAS CAUSED BY: <u>Ami triptyline intoxication</u> | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>9503</u> | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| | | | 3:30 P.M. 4/3/84 | | self ingested | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | |
| | | | home | | 1117 Paca Dr. Edgewater, Maryland | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE | | | TITLE (SPECIFY) | | | DATE SIGNED | | |
| Margarita A. Korell, M.D. | | | Assistant | | | 4-4-84 | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | ADDRESS | | | | | |
| | | | 111 Penn Street | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Cremation | | | April 5, 1984 | | Cedar Hill | | Suitland P.G. MD | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | |
| Taylor Funeral Chapel-Annapolis MD | | | APR 11 1984 | | | Julia Davidson-Randell | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME
(TYPE OR PRINT) | | FIRST MIDDLE LAST
<i>Charles A. ZANG</i> | | 2b. DATE OF DEATH
MONTH DAY YEAR
<i>4/30/84</i> | | 2c. HOUR
<i>2:30 PM</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>WHITE</i> | | 5. DATE OF BIRTH
MONTH DAY YEAR
<i>1/2/04</i> | | 6. AGE (IN YEARS LAST BIRTHDAY)
<i>80</i> | |
| 7a. BIRTHPLACE
(COUNTRY) STATE OR FOREIGN
<i>Baltimore, Md.</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U. S.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH
<i>Anne Arundel Co., MD.</i> | |
| 10. CITY OR TOWN OF DEATH
<i>Glen Burnie</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)
<i>North Arundel Convalescent Home</i> | | 12a. USUAL OCCUPATION
(TYPE OF WORK FOR MOST OF WORKING LIFE)
<i>Locksmith</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>City</i> | |
| 13a. STATE
<i>MD.</i> | | 13b. COUNTY
<i>A.A.</i> | | 13c. CITY OR TOWN
<i>Pasadena</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
FIRST MIDDLE LAST
<i>William Zang</i> | | 15. MOTHER'S MAIDEN NAME
FIRST MIDDLE LAST
<i>Sophia Etzel</i> | | 13e. STREET ADDRESS / ZIP CODE
<i>224 Chelsea Rd., 21122</i> | | 13f. CITY OR COUNTY OF DEATH
<i>Riviera Beach</i> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO OR UNKNOWN)
<i>No</i> | | 16b. SOCIAL SECURITY NO.
<i>219-14-0593</i> | | 17. INFORMANT
ADDRESS
<i>Thelma Zepp, 1702 Johnson St., 21230</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>
<i>4340</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Small vessel disease of the brain</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Cerebral arteriosclerosis</i> | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:
<i>none</i> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>
OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
<i>P.M. 19</i> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION
STREET CITY OR TOWN COUNTY STATE
<i>3708 Mountain Rd. Pasadena, Md.</i> | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <i>May 26, 1958</i> to <i>April 30, 84</i> , that (I) (we) last saw the deceased alive on <i>April 28, 1984</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>R. M. McLaughlin, M.D.</i> | | DEGREE
<i>M.D.</i> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED
<i>4/30/84</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)
<i>R. M. McLaughlin, M.D.</i> | | 22e. ADDRESS
<i>3708 Mountain Rd. Pasadena, Md.</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)
<i>Burial</i> | | 23b. DATE
<i>5/3/1984</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>New Cathedral Cem.</i> | | 23d. LOCATION
CITY OR TOWN COUNTY STATE
<i>Baltimore, Maryland</i> | |
| 24. FUNERAL DIRECTOR
<i>George J. Gonce, 4001 Ritchie Hg., Baltimore, Md.</i> | | | | 25a. DATE REC'D. BY REGISTRAR
<i>MAY 4 1984</i> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED



20%